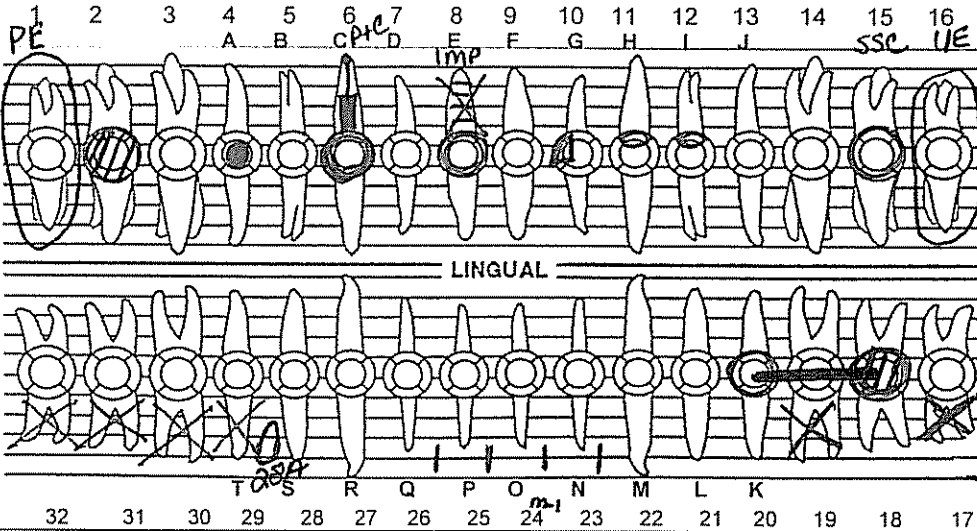


DENTAL EXAMINATION

PATIENT NAME (Last, First) **SMITH, JOHN J.** DOC NUMBER **600000** SEX **M** DOB (mm/dd/yy) **04/14/1988** FACILITY NAME **DCI** DATE ADMITTED **06/11/2012**

RACE White Black American Indian or Alaskan Native Asian or Pacific Islander Other
ETHNICITY Hispanic Non-Hispanic

EXISTING RESTORATIONS & MISSING TEETH



EXAM TYPE
 Intake Periodic Urgent Exam

PATIENT'S CHIEF COMPLAINT
Pain #28

PERIODONTAL CONDITION

DIAGNOSIS Gingivitis Periodontitis
AAP: I II III IV V
COMMENTS

PSR:

2	2	2
2	2	2

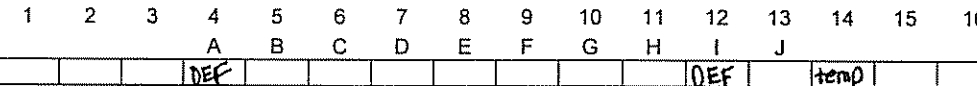
SOFT TISSUE EXAMINATION	WNL	COMMENTS
LYMPH NODES	<input checked="" type="checkbox"/>	1) metal pins anterior mandible for fractured jaw #22-26 (1999) 2) Retained root tip #17- no pathology 3) #24 slightly mobile- m-1 4) #31 retained root tip with periapical abscess 5) Patient wears orthodontic retainer fabricated by Dr Jones in 1999. Phone: 920-888-8888
PHARYNX	<input checked="" type="checkbox"/>	
TONSILS	<input checked="" type="checkbox"/>	
SOFT PALATE	<input checked="" type="checkbox"/> (L) cleft-untreated	
HARD PALATE	<input checked="" type="checkbox"/>	
FLOOR OF MOUTH	<input checked="" type="checkbox"/>	
LIPS	<input checked="" type="checkbox"/> (L) cleft-untreated	
SKIN	<input checked="" type="checkbox"/>	
TMJ	<input checked="" type="checkbox"/> slight click	
TONGUE	<input checked="" type="checkbox"/>	
VESTIBULES	<input checked="" type="checkbox"/>	
BUCCAL MUCCOSA	<input checked="" type="checkbox"/>	

ORAL HYGIENE	Excellent	Good	Fair	Poor
ORAL HYGIENE	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CALCULUS	<input type="checkbox"/> None	<input checked="" type="checkbox"/> Little	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
GINGIVAL BLEEDING	<input checked="" type="checkbox"/> Localized	<input type="checkbox"/> General	<input type="checkbox"/>	<input type="checkbox"/>
OCCLUSION (Angle)	<input checked="" type="checkbox"/> I	<input type="checkbox"/> II	<input type="checkbox"/> III	<input type="checkbox"/>

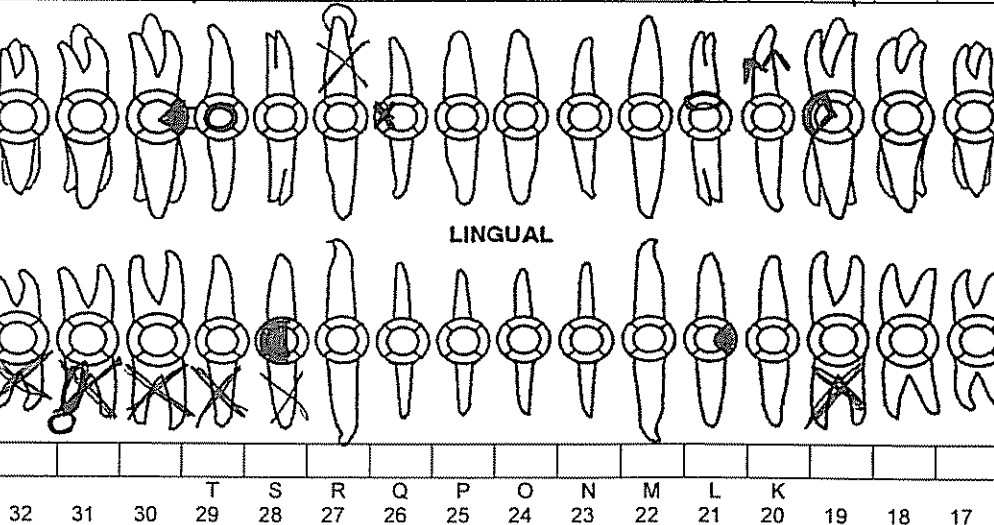
PROSTHESIS EVALUATION
TYPE AREA MATERIAL
 Full Max Mand Acrylic
 Partial Max Mand Cast

AGE _____ Max **4 years** Mand
FUNCTION Poor Adequate
CONDITION Poor Adequate

PATHOLOGY / TREATMENT INDICATED/ MISSING TEETH



DENTAL CLASSIFICATION:
 10 20 35 36 40 80



X-RAYS MADE:
Type & Number
 Panoramic **1**
 BWX **2**
 PAX
Check if Digital
Reviewed by Dentist

POC-0074
 Pathology Discussed with Patient

DENTIST SIGNATURE & STAMP **A. Dentist, DDS** EXAM DATE **07/01/2012**
A. DENTIST, DDS