Dental Exam Form

Client Name _________________________________   Date of Visit:__________
DDS Name___________________________________
Reason for Visit/Chief Complaint:________________________________________

____________________________________________________________________
____________________________________________________________________

Staff completing forms ___________________ Staff Accompanying____________________

*Provider to complete upper section, attach Health Record Form and Current MAR and bring to the appointment*

Exam Results for DDS to complete:

1. Does consumer have all of his natural teeth? _____YES     _____NO
   If “No” – Mark on diagram those missing with an “X”.

2. Do any teeth have visible evidence of decay? _____YES     _____NO
   If “Yes” – list #’s_______________________________________________________

3. Are any teeth broken? _____YES     _____NO
   If “Yes” – list #’s_______________________________________________________

4. Are any teeth loose? _____YES     _____NO
   If “Yes” – list #’s_______________________________________________________

5. Does consumer have a prosthesis? _____YES     _____NO
   If “Yes” – list #’s_______________________________________________________

6. Does consumer have dentures? _____YES     _____NO
   If “Yes” ______Upper ______Lower ______Both

7. Are gums overgrown at base of teeth? _____YES     _____NO

8. Is there any visible evidence of white spots, black spots or ulcerations?
   On the cheeks _____YES     _____NO
   On the roof _____YES     _____NO
   On/Under the tongue _____YES     _____NO
   If “Yes” – list & describe:_________________________________________________

9. Is oral mucosa shiny and pink? _____YES     _____NO

10. Does consumer complain of pain or discomfort?
    In mouth _____YES     _____NO
    With teeth _____YES     _____NO
    With Dentures _____YES     _____NO
    If “Yes” – list & describe:_________________________________________________

11. Is consumer capable of:
    Brushing natural teeth _____YES     _____NO
    Brushing/cleaning dentures _____YES     _____NO
    Flossing _____YES     _____NO

Recommendations/New Orders:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Dentist’s Signature __________________ Date

FOLLOW UP APPOINTMENT DATE/TIME:_________________________________________
Name of Nurse/Supervisor Notified of Above: __________________ Date/Time Notified:__________
Staff Notifying: ___________________ Medications Received Date/Time/Initials ___________
Order Transcribed and checked by 2 staff -- Date/Time/Initials ___________
Outreach Services of Indiana/adapted from Carey Services Dental Exam Form

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Dental Form 1