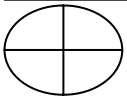
INITIAL EXAM FORM

PATIENT NAME: **DATE:**

Concerns	Solutions
1.	1.
2.	2.
3.	3.
4.	4.

Hygiene/Perio

Last Recall: _____ **Brush** _____
Floss: **Bleed w Flos:**
Tartar: **Bone Loss:**
Inflam: **Bleed U Prob:**



Esthetics

Smile Score: _____
Whitening: _____

Initial OD Examination

Occ. Wear/FX: _____
CDH: _____
Hypermobility: _____
Vert. Bone Loss: _____
Abfractions: _____
Fremitus: _____
Muscle or TMJ Pain:

Medical & Dental Referral

Ref Endo: _____ **Ref OS:** _____
Ref Perio: _____
Ref Ortho: _____
Ref TMJ: _____
Oral Cancer: _____
Medical Clearance: _____

Diagnosis / Prevention

Periodonal: _____
OD: _____ _____
Caries: _____

TX PLAN #1 - BASIC

Records

MIP: _____ **CR:** _____
OD:
DFED:

	EXISTING CONDITIONS		TX PLAN #1 - BASIC		TX PLAN #2 - IDEAL
1		1		1	
2		2		2	
3		3		3	
4		4		4	
5		5		5	
6		6		6	
7		7		7	
8		8		8	
9		9		9	
10		10		10	
11		11		11	
12		12		12	
13		13		13	
14		14		14	
15		15		15	
16		16		16	
17		17		17	
18		18		18	
19		19		19	
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21		21		21	
22		22		22	
23		23		23	
24		24		24	
25		25		25	
26		26		26	
27		27		27	
28		28		28	
29		29		29	
30		30		30	
31		31		31	
32		32		32	