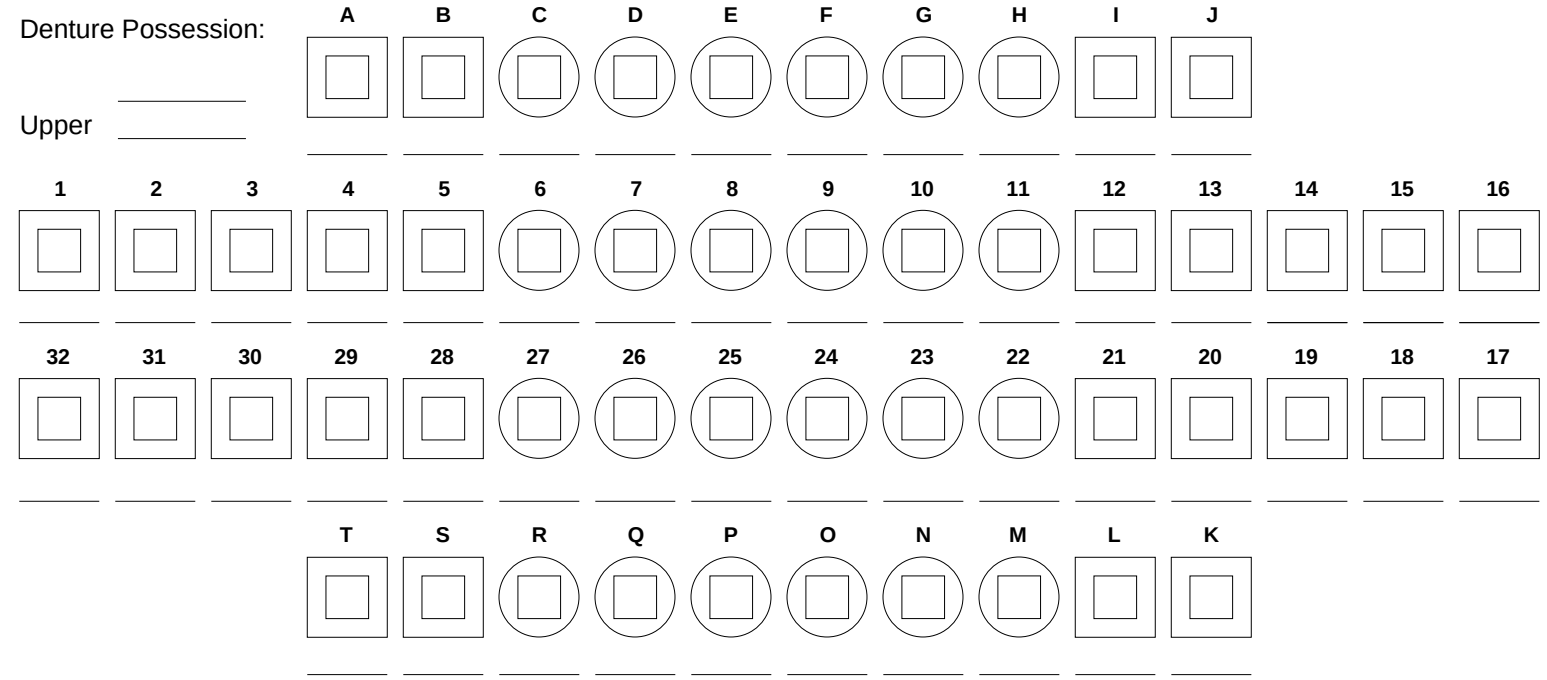
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service Indian Health Service

DENTAL EXAMINATION RECORD

PART III. ORAL DIAGNOSIS

Denture Possession:

Upper _____



Periodontal Diagnosis: _____

X-rays Reviewed: _____

Enamel Defects: _____

Soft Tissue/TMJ: _____

Orthodontics:
☐ No. Need ☐ Tx. in Progress ☐ Completed

Date	Date	Date

Therapy or Evaluation Needed: _____

PART V. TREATMENT PLAN

Referral / Followup: _____ Interval: _____

This treatment plan has been explained and I accept it.

Patient / Guardian _____ Date: _____

Dentist _____ Date: _____

IV. PREVENTION ASSESSMENT

Status of:

Water Fluoride _____ ppm
Use of Fluoride Toothpaste _____
Other Fluoride Supplements _____
Oral Hygiene _____
Tobacco Use _____
Need for: _____
Topical Fluoride _____
Fluoride Tablets/Drops _____
Sealants _____
Hygiene Instruction _____
Other Education _____
Target Group: _____

VI. DEFERRED DENTAL NEEDS

Basic Care (level I - III Svcs) _____
Anterior/Bicuspid Endo _____
Molar Endodontics _____
Perio Pocket Therapy _____
Crowns/Complex Restor. _____
Removable Dentures _____
Fixed Bridge: Ant. _____ Post. _____
Surgery: 3rd Molars _____ Other _____
Ortho: Limited _____ Comp _____

PART I. DEMOGRAPHICS

HRN SSN

NAME

B DATE SEX TRIBE

RESIDENCE

FACILITY DATE

PART II. MEDICAL ALERT / UPDATE

EF