DENTAL EXAMINATION

Date: _____ Doctor: _____

Participant's Name: _____ DOB: _____

Staff escorting to appointment: _____

Allergies: See Attached

Current Medications, Dx's and Diet: See Attached

Reason for Appointment/ Comments:

TO BE COMPLETED BY ATTENDING PHYSICIAN

Are there any decayed teeth? ☐ Yes ☐ No

Is the gum tissue normal? ☐ Yes ☐ No

Do the teeth show evidence Of proper brushing? ☐ Yes ☐ No

Is there infection present? ☐ Yes ☐ No

Are X-Rays necessary? ☐ Yes ☐ No

Are abnormalities present? ☐ Yes ☐ No

Comments:

_____ _____

Physician Signature Date

_____

Printed Physician Name

_____ _____

Next Appointment Referral if Necessary

DENTAL CONSENT

Based on the above, I

Check One

☐ Do Agree

☐ Do Not Agree

I was informed of the dental exam and treatment involved, I

Check One

☐ Do Agree

☐ Do Not Agree

Participant Signature	Date
Guardian Verbal (If Applicable)	Date
Guardian Written (If Applicable)	Date

MEDICAL APPOINTMENT NARRATIVE

Participant (print): _____ Date: _____

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Signature Title