

ABDD DENTAL REPORT

Name:	DOB:	Date and Time of Appointment:
Address:		Guardian (if applicable):
Insurance Information and MA#:		
Allergies/Sensitivities:		
Health Care Provider:		Phone:
Address:		Specialty:
Current Medications		

Overall Oral Hygiene for This Report Period: ___ Good ___ Fair ___ Poor

This appointment is for:

___ **6 Month Cleaning** ___ **12 Month Cleaning** _____

___ **Initial Exam** ___ **Consultation** _____

___ **Filling** ___ **Extraction** _____

___ **Other:** _____

Radiographic Survey Was:
 _____ Not Indicated
 _____ Not Feasible Due to Lack of Cooperation
 _____ Results of X rays _____

This Edentulous/Partially Dentulous Individual:
 _____ Full Dentures
 _____ Partial Dentures (Removable)
 _____ Fixed Bridge (Not Removable)

Has Not Been Provided With Any Prosthetic Replacement Due To:
 _____ Inability to Cooperate for This Procedure
 _____ Lack of Substantial Bony ridges to Support a prosthesis

This Individual Will Be Seen in The Future For:
 _____ Routine (Please circle one) 3 Months 6 Months Annual
 _____ Restoration (s)
 _____ Extraction (s)
 _____ Evaluation for Prosthetic Replacement

Name: _____

Goals for This Individual Are:

- _____ To Improve the Level of Oral Hygiene
- _____ To Maintain the Present Level of Oral Hygiene

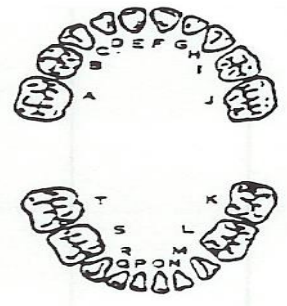
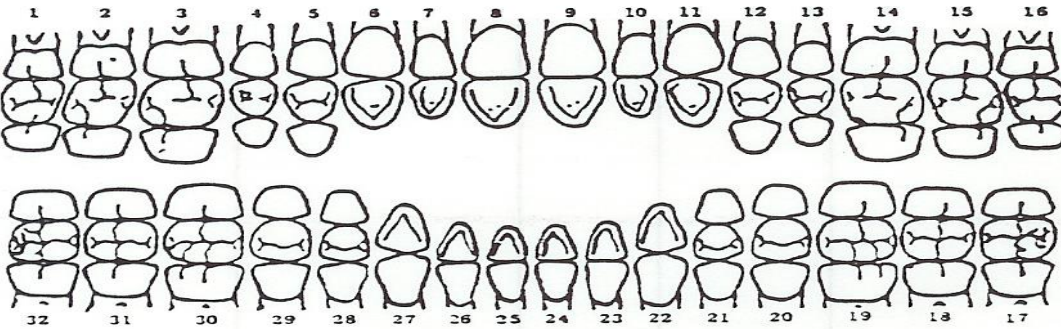
The Individual Should Be:

- _____ Brushed by Attendant Staff
- _____ Examined after brushing by staff to see if areas have been missed. Staff will provide assistance as necessary
- _____ Is able to brush teeth with verbal reminders

Did this person receive pre-medication or sedation for this appt? _____

Type of pre-medication or sedation: _____

Services Rendered and Additional Comments and Recommendations:



Physician's Signature: _____

Address: _____

Date: _____

ABDD Staff Print Name: _____ Date: _____

Return Visit Needed? Yes: _____ No: _____

Date and time of follow up appointment: _____