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:**

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

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

Name_____

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

Type of pre-medication or sedation: _____

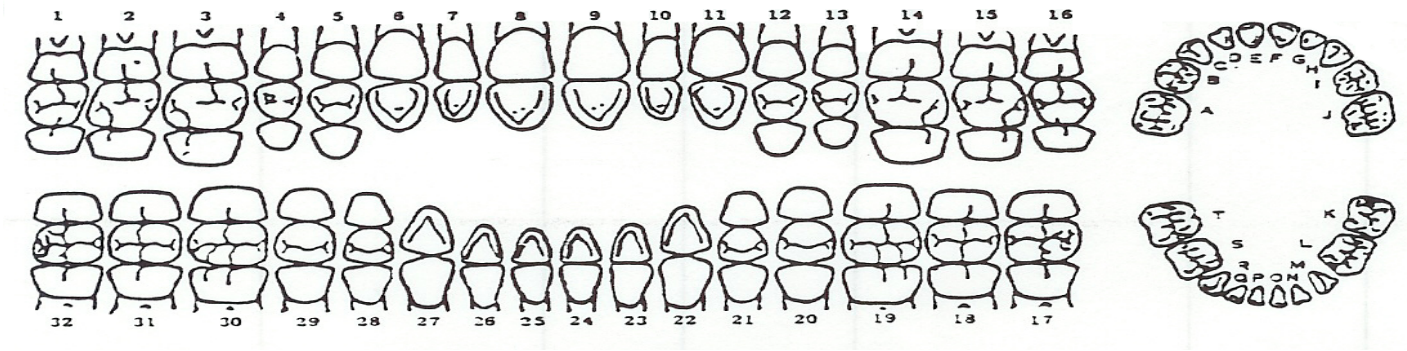
Services Rendered and Additional Comments and Recommendations:

List of Medications:

Staff Signature: _____Date:_____

Return Visit Needed? Yes:_____ No:_____

Date and time of follow up appointment: _____



Physician's Signature:_____

Address:_____

Date:_____