SCOTT KEY CENTER
HELPING SHAPE FUTURES

Dental Examination Form

Date:_____

Name: _____ Age: _____ Sex: _____

Address: _____

Previous Extractions: ( ) Local Anesthesia ( ) General Anesthesia

( ) Slight Bleeding ( ) Bleeding Normal ( ) Bleeding Heavy

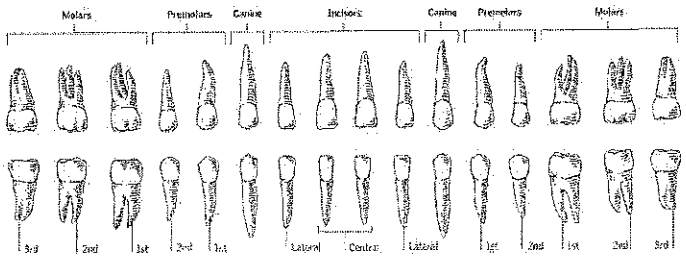
Post Operative: Healing: ( )Normal ( ) Surgical Dressings

Osteitis:

_____

_____

Treatment Performed At:



ORAL EXAMINATION

Gingiva: Maxilla _____

Mandible _____

Growths: _____

_____

Occlusion: _____

_____

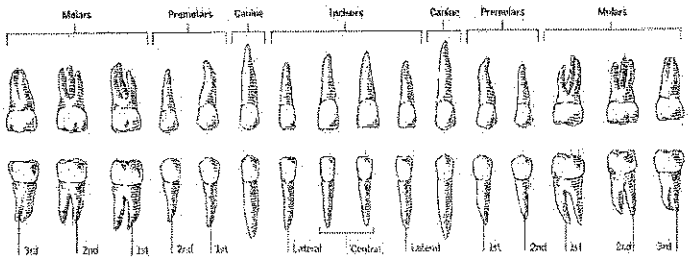
Ulcerations: _____

_____

Other Conditions: _____

_____

Missing Teeth and Existing Restorations
Indicated Work:



DENTURES

Maxilla: _____

Mandible: _____

Services Rendered: _____

_____

Recommendations: _____

_____

Dentist's Signature: _____

Name Printed: _____

Address: _____

_____

Phone: _____