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# Dental Examination Form PDF

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## Patient Details

- Name: \_\_\_\_\_
- Age: \_\_\_\_\_
- Patient ID: \_\_\_\_\_

## Dental History

- Last Visit: \_\_\_\_\_
- Current Treatment: \_\_\_\_\_
- X-rays: Yes [ ] No [ ]

## Examination Results

- Teeth Condition: \_\_\_\_\_
- Gum Health: \_\_\_\_\_

## Treatment Plan

- Procedures Needed: \_\_\_\_\_
- Scheduled Procedures: \_\_\_\_\_

## Dentist Confirmation

- Signature: \_\_\_\_\_
- Date: \_\_\_\_\_