**Dental Checkup Examination Form**

**Patient Information  
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Gender: [ ] Male [ ] Female  
Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Preferred Appointment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Examination Checklist  
[ ] Teeth Cleaning  
[ ] Cavity Check  
[ ] X-Ray Analysis  
[ ] Orthodontic Consultation**

**Teeth Condition**

| **Teeth Area** | **Normal** | **Requires Attention** | **Notes** |
| --- | --- | --- | --- |
| **Upper Front Teeth** | **[ ]** | **[ ]** |  |
| **Lower Front Teeth** | **[ ]** | **[ ]** |  |
| **Upper Molars** | **[ ]** | **[ ]** |  |
| **Lower Molars** | **[ ]** | **[ ]** |  |

**Dentist Comments:**

**Next Steps  
Follow-Up Appointment: [ ] Yes [ ] No  
If Yes, Preferred Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dentist’s Signature  
Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**