**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: \_\_\_\_\_\_\_\_\_\_\_**