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: _____