**Dental Treatment Examination Form**

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

**Gender: [ ] Male [ ] Female  
Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dental History  
Have you experienced any of the following? (Check all that apply):  
[ ] Tooth Pain  
[ ] Sensitivity to Hot/Cold  
[ ] Bleeding Gums  
[ ] Previous Dental Treatments**

**Examination Findings**

| **Area Examined** | **Issue Detected** | **Treatment Needed** | **Comments** |
| --- | --- | --- | --- |
| **Upper Jaw** | **[ ] Yes [ ] No** | **[ ] Yes [ ] No** |  |
| **Lower Jaw** | **[ ] Yes [ ] No** | **[ ] Yes [ ] No** |  |
| **Gums** | **[ ] Yes [ ] No** | **[ ] Yes [ ] No** |  |

**Recommended Treatments**

* **Fillings: [ ] Yes [ ] No**
* **Cleaning: [ ] Yes [ ] No**
* **Root Canal: [ ] Yes [ ] No**
* **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dentist Approval  
Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**