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