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: ____

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Dentist Approval

Signature: ___________________________ Date: ___________

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