
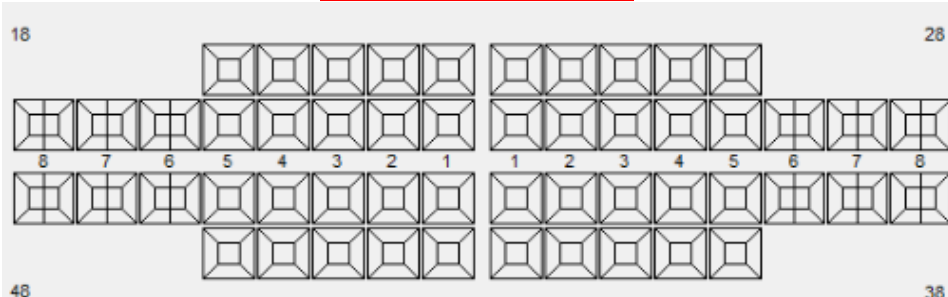







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Dental and Oral Health Checking

Please answer the following questions:

<p>Gum</p> <input type="checkbox"/> Do your gum bleed during brushing? <input type="checkbox"/> Do you have swollen/red gum? <input type="checkbox"/> Do your teeth look longer? <input type="checkbox"/> Do your teeth easily stuck with food?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	 <p>Patient name: _____ Clinic Chop/Sticker: _____</p> <p>RN: _____</p>
<p>Teeth</p> <input type="checkbox"/> Do you have any missing tooth? <input type="checkbox"/> Do you have any tooth ache lately? <input type="checkbox"/> Do you have sensitive teeth? <input type="checkbox"/> Do you satisfied with your teeth color? <input type="checkbox"/> Are you confident of your smile?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Breath</p> <input type="checkbox"/> Do you think you have bad breath? <input type="checkbox"/> Are you confident to smile and talk to a person in close range, e.g. in 1-2 feet	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Smoking and staining</p> <input type="checkbox"/> Do you smoke? <input type="checkbox"/> Are your teeth stain?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Pain/Discomfort</p> <input type="checkbox"/> Any teeth or gum pain or discomfort?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<h3>DENTAL CHARTING</h3>	<h3>Breath Testing *Optional</h3>
	<p>Reading BREATH ODOUR LEVEL</p> <input type="checkbox"/> 0 No Odour <input type="checkbox"/> 1 Slight Odour <input type="checkbox"/> 2 Moderate Odour <input type="checkbox"/> 3 Heavy Odour <input type="checkbox"/> 4 Strong Odour <input type="checkbox"/> 5 Intense Odour <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  Very good </div> <div style="text-align: center;">  Normal </div> <div style="text-align: center;">  Not so good </div> <div style="text-align: center;">  Bad </div> <div style="text-align: center;">  Very bad </div> </div>

For Office Use Only:

<p>Provisional Diagnosis</p>			
<p>Soft Tissue</p> <input type="checkbox"/> Gingivitis <input type="checkbox"/> Periodontitis <input type="checkbox"/> Mobile tooth <input type="checkbox"/> Dental abscess <input type="checkbox"/> Sinus Tract	<p>Hard Tissues:</p> <input type="checkbox"/> Dental caries <input type="checkbox"/> Impacted tooth <input type="checkbox"/> Fractured tooth <input type="checkbox"/> Discolored tooth <input type="checkbox"/> Missing tooth	<p>Dental abrasion</p> <input type="checkbox"/> Deep fissure <input type="checkbox"/> Dental attrition <input type="checkbox"/> Others:	<p>Alignment/ Malocclusion:</p> <input type="checkbox"/> Protrusion <input type="checkbox"/> Crowding <input type="checkbox"/> Spacing <input type="checkbox"/> Protrusion <input type="checkbox"/> Retrusion
<p>Treatment plans/ advice:</p>			
<input type="checkbox"/> Scaling and polishing <input type="checkbox"/> Scaling and stain removal <input type="checkbox"/> Fissure sealant <input type="checkbox"/> Topical Fluoride <input type="checkbox"/> Filling <input type="checkbox"/> Crown/veneer <input type="checkbox"/> Replace missing teeth (Denture, implant, , Bridge) <input type="checkbox"/> Braces evaluation (Models & Xray) <input type="checkbox"/> Extraction <input type="checkbox"/> Wisdom tooth evaluation/removal	<input type="checkbox"/> Root canal treatment with/without crown <input type="checkbox"/> Gum Recontouring <input type="checkbox"/> Teeth whitening <input type="checkbox"/> Minor oral surgery <input type="checkbox"/> Periapical Xray <input type="checkbox"/> 3D Xray <input type="checkbox"/> Braces/Orthodontic evaluation <input type="checkbox"/> Cosmetic and smile evaluation <input type="checkbox"/> Temporomandibular joint (TMJ) evaluation <input type="checkbox"/> Bite/Occlusal analysis <input type="checkbox"/> Sleep apnea analysis		

Date: _____ Assistant: _____ Examiner/Doctor: _____

*Patient master copy. Please bring this form if any further treatment is necessary.