



TWIN PINES FAMILY SERVICES, LLC

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DENTAL EXAMINATION FORM

PATIENT'S NAME: _____ EXAM DATE: _____

DATE OF BIRTH: _____ RACE: _____ GENDER: ☐ MALE ☐ FEMALE

☐ ORIGINAL APPOINTMENT

☐ RESCHEDULED APPOINTMENT: ☐ BY OFFICE ☐ BY FOSTER PARENT

SERVICES PROVIDED:	
☐ ORAL EXAMINATION	☐ ORTHODONTIC EVALUATION
☐ PROPHYLAXIS	☐ ORTHODONTIC ADJUSTMENT
☐ SEALANTS	☐ ORTHODONTIC RETENTION
☐ FLUORIDE TREATMENT	☐ NUMBING/LOCAL ANESTHESIA
☐ AMALGAM(S) HOW MANY?	☐ SEDATION/GENERAL ANESTHESIA
☐ X-RAYS	☐ TOOTH EXTRACTION(S) HOW MANY?
☐ REFERRAL TO SPECIALIST (ATTACHED)	☐ CROWN(S) HOW MANY?
☐ OTHER: _____	

NUMBER OF CAVITIES: _____

ORAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR

RECOMMENDATIONS AND/OR COMMENTS:

☐ ADDITIONAL TREATMENT REQUIRED: SCHEDULED FOR:

DAY: MON TUES WEDNES THURS FRI SAT SUN DATE: _____

☐ RETURN IN SIX MONTHS FOR ROUTINE CLEANING/EXAM. SCHEDULED FOR:

DAY: MON TUES WEDNES THURS FRI SAT SUN DATE: _____

DENTIST'S SIGNATURE

DATE

OFFICE NAME/ADDRESS/PHONE NUMBER