Human Resources Center, Inc.
DENTAL EXAM AND HYGIENE PLAN FORM

Name of Client:____Date: ________________________

Dentist: ____

Current Medications: ____

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Initial Dental Screening: Cavities:____

Protrusion:____

Missing Permanent teeth:______________________________________

Oral Infection:____

Condition of teeth:____

Procedure performed: X-Ray:__________________Denture Check:______________________

Cleaning:________________ Gum Check:_________________________

Additional Procedures performed (if applicable):____

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Follow-up Treatment:____

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Current Method of Dental Hygiene: ____

Recommended Dental Hygiene:____

Special Considerations: ____

If the individual refuses evaluation and/or treatment, physician's statement and recommendations: _____

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Recommended Frequency of Dental Examinations:____

Date of Next Examination: ____

____ ____________________________

Dentist's Signature Date