

ODONTOGRAM AND CLIENT ASSESSMENT

CLIENT'S NAME: _____

GENDER: M / F

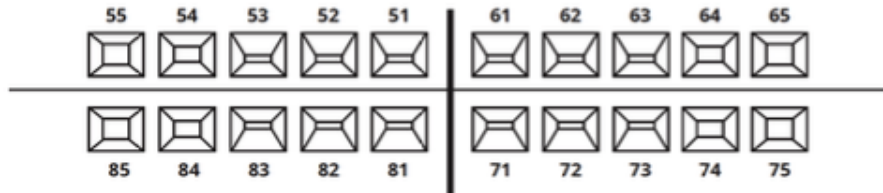
BIRTHDATE (DD/MM/YYYY): ___/___/___

AGE: _____

STATUS #: _____

MEDICAL ALERT

PROBE	DATE	3																		3	INT
	DATE	2																		2	
	DATE	1																		1	
			18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28			
	FACIAL																				
	R																			L	
	LINGUAL																				
PROBE		1																		1	INT
		2																		2	
		3																		3	



PROBE	DATE	3																		3	INT
	DATE	2																		2	
	DATE	1																		1	
	LINGUAL																				
	R																			L	
	FACIAL																				
PROBE	DATE	1																		1	INT
	DATE	2																		2	
	DATE	3																		3	

Client Name:	Date:	Client Name:	Date:																																																												
EOE/IOE/SOFT TISSUE: <input type="checkbox"/> WNL <input type="checkbox"/> Findings <input type="checkbox"/> Lesion tracking sheet completed		EOE/IOE/SOFT TISSUE: <input type="checkbox"/> WNL <input type="checkbox"/> Findings <input type="checkbox"/> Lesion tracking sheet completed																																																													
Dental Biofilm/Deposits		Dental Biofilm/Deposits																																																													
Plaque control: Good Fair Poor Soft deposit: Loc Gen Interprox GingMargin Calculus: Supragingival Loc Gen Light Moderate Heavy Subgingival Loc Gen Light Moderate Heavy Stain: 0 1 2 3 Loc Gen	BOP: <input type="checkbox"/> Loc <input type="checkbox"/> Gen <input type="checkbox"/> Light <input type="checkbox"/> Mod <input type="checkbox"/> Heavy	Plaque control: Good Fair Poor Soft deposit: Loc Gen Interprox GingMargin Calculus: Supragingival Loc Gen Light Moderate Heavy Subgingival Loc Gen Light Moderate Heavy Stain: 0 1 2 3 Loc Gen	BOP: <input type="checkbox"/> Loc <input type="checkbox"/> Gen <input type="checkbox"/> Light <input type="checkbox"/> Mod <input type="checkbox"/> Heavy																																																												
Periodontal Assessment		Periodontal Assessment																																																													
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TMJ Exam		TMJ Exam																																																													
Normal Range of motion: Open Close Lateral (R / L) _____ Pain: None Slight Moderate Severe _____ Sounds: Opening Closing Lateral (R / L) _____	Appliance / Prosthetic Y N _____ _____	Normal Range of motion: Open Close Lateral (R / L) _____ Pain: None Slight Moderate Severe _____ Sounds: Opening Closing Lateral (R / L) _____	Appliance / Prosthetic Y N _____ _____																																																												

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