**INITIAL CLINICAL EXAM**

**PATIENT’S NAME**

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**GINGIVA**

**MOBILITY**

**PROTHESES EVALUATION**

**OCCLUSION** 1 11 111

**PATIENT’S CHIEF COMPLAINT**

**CLINICAL FINDINGS/COMMENTS**

- LYMPH NODES
- PHARYNX
- TONSILS
- SOFT PALATE
- HARD PALATE
- FLOOR OF MOUTH
- TONGUE
- VESTIBULES
- BUCCAL MUCOSA
- LIPS
- SKIN
- TMJ
- ORAL HYGIENE
- PERIO EXAM

**RADIOGRAPHS**

**B/P**

**RDH/DDS**

**RECOMMENDED TREATMENT PLAN**

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<th>TOOTH OR AREA</th>
<th>DIAGNOSIS</th>
<th>PLAN A</th>
<th>PLAN B</th>
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**SIGNATURE OF DENTIST**

**DATE**

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**Note:** The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.