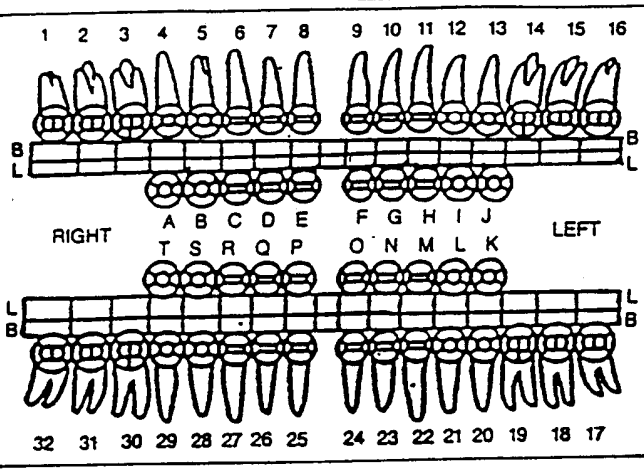
ALLERGY	PRE MED	MEDICAL ALERT

INITIAL CLINICAL EXAM

PATIENT'S NAME _____ Last First Middle



GINGIVA
MOBILITY
PROTHESIS EVALUATION
OCCLUSION 1 11 111
PATIENT'S CHIEF COMPLAINT

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

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

RECOMMENDED TREATMENT PLAN

TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST DATE

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.