

Patient Treatment Record



Name _____ DOB _____

Oral Hygiene Assessment:

_____ **Good** (brushes 1-2 a day, plaque none-minimal, no inflammation)

_____ **Fair** (brushes occasionally, plaque minimal-moderate, isolated inflammation)

_____ **Poor** (no oral hygiene, inflammation, bleeding)

(Provider must initial next to service)

I. Oral Hygiene Instruction:

Brushing Instruction _____ Comment _____

Flossing Instruction _____ Comment _____

Nutrition Counseling _____ Comment _____

II. Dental Cleaning:

Prophylaxis _____ Comment _____

Fluoride Treatment _____ Comment _____

III. Orthodontic Evaluation:

Examination _____ Comment _____

Habits: Pacifier _____ Thumbsucking _____ Bruxism _____

Findings: Crowded _____ Spaced _____ Crossbite _____

IV. Dental Examination:

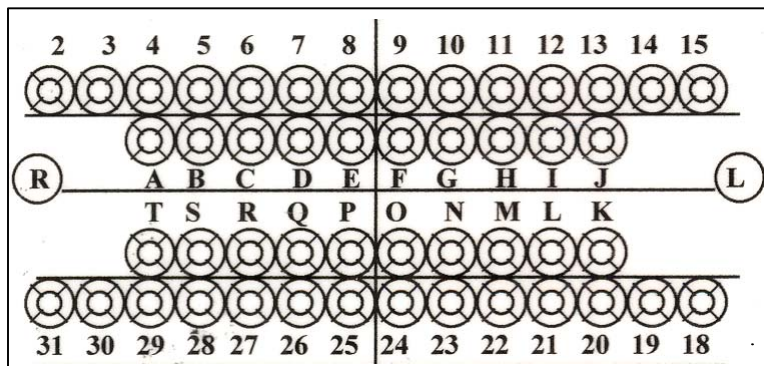
Examination _____ Comment _____

Radiographs _____ BW _____ Occ _____ PA _____ Pan _____

V. Charting:

Please use key to chart

Key	
Sealants -	S
Pulpotomy -	P
Extraction -	X
Restorative -	O



VI. Today's Treatment

Signature

Sealants: Teeth _____

Pulpotomy: Teeth _____

Extraction: Teeth _____

Restorative: Teeth _____