PERIODONTAL SCREENING

Plaque _____ Calculus _____

					LOCATION
Subgingival furcations	None _____	Class I _____	Class II _____	Class III _____	_____
Pockets ……	None _____	3-4mm _____	4-6mm _____	Over 6mm _____	_____
Recession ……	None _____	1-2mm _____		Over 3mm _____	_____
Mobility ……	None _____	Class I _____	Class II _____	Class III _____	_____
Bleeding on Probing ..	None _____	Slight _____	Moderate _____		

Radiographic findings: _____ ☐ angular bone loss

Findings and recommendations shared with patient: _____ ☐ Treat ☐ Refer ☐ Maintain

HEAD AND NECK SOFT TISSUE SCREENING

INTRAORAL

W.N.L. ☐ or LESION: Lips _____ Tongue _____ Giniva _____

Mucosa _____ Pharynx _____ Edentulous _____

Color/Size _____ Palate _____

Describe _____

EXTRAORAL

W.N.L. ☐ or LESION: Face _____ Neck _____ Lymph Nodes _____

Describe _____

Red ☐
Purple ☐
Irregular Contour ☐
Blunt Papilla ☐
Puffy Papilla ☐
Gingivitis ☐
Exudate ☐
Tori Max. ☐ Mand. ☐
Treat ☐ Refer ☐

TMJ/OCCLUSION SCREENING

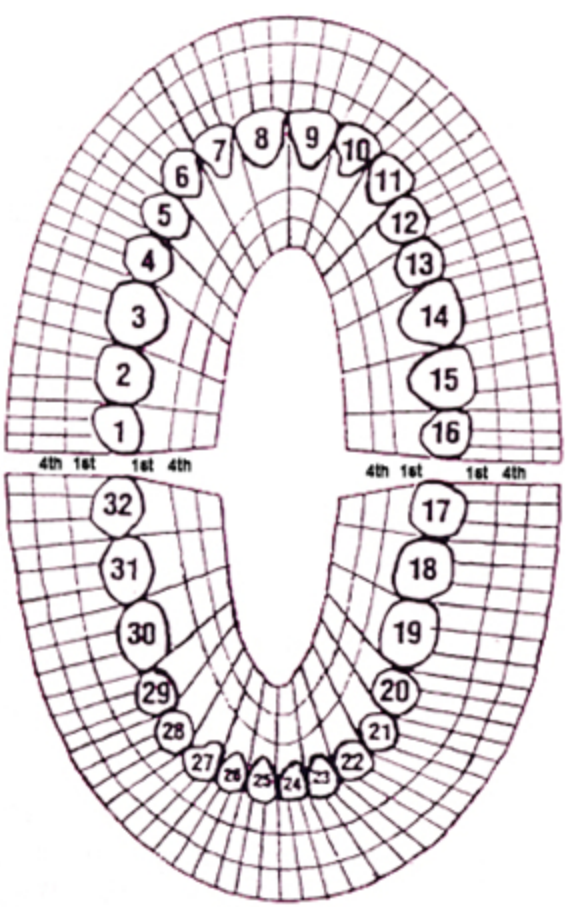
W.N.L. ☐

CREPITIS	No ☐	Left ☐	Right ☐		
BRUXISM	No ☐	Yes ☐	Frequency _____		
PAIN	No ☐	Headache ☐	Earache ☐	Left ☐	Right ☐
MUSCLE SPASM	No ☐	Left ☐	Right ☐		
EXISTING APPLIANCE OR PREVIOUS TREATMENT		No ☐	Yes ☐		

TMJ/OCC IMPRESSION:

☐ Treat ☐ Refer ☐ Maintain

PERIODONTAL SCREENING AND RECORDING



UL
1st Visit _____
Recall _____
Recall _____

UA
1st Visit _____
Recall _____
Recall _____

UR
1st Visit _____
Recall _____
Recall _____

LL
1st Visit _____
Recall _____
Recall _____
Recall _____

LA
1st Visit _____
Recall _____
Recall _____
Recall _____

LR
1st Visit _____
Recall _____
Recall _____
Recall _____

Case Types
- ☐ Case Type I Gingivitis
- ☐ Case Type II Slight Periodontis
- ☐ Case Type III Moderate Periodontis
- ☐ Case Type IV Advanced Periodontitis
- ☐ Case Type V Refractory Progressive Periodontitis

CODES
C= Redness
P= Pus Exudate
B= Bleeding Points
R= Recession
X= Missing Tooth
E= To Be Extracted

MOBILITY GRADES
0 Normal
+1 Facial-Lingual 1mm+
+2 Mesial Distal 1mm+
+3 Both +1 and +2
+4 Depression and/or Rotation in Socket

FURCATION GRADES
F1: Just able to probe root indention
F2: Probe penetrates into furcation
F3: Probe penetrates thuough furcation filled with soft tissue
F4: Furcation is open and void of soft tissue

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Code																
Mobility																
Furcation																

	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Code																
Mobility																
Furcation																

Date _____ Home Phone _____

Last Name _____ First _____ Middle _____ Office Phone _____

Date of Birth _____ Age _____ Social Security No. _____ Driver's License _____

Home Address _____ City _____ ZIP _____

Your Occupation _____ Employer _____ Years with firm _____

Employer's Address _____ City _____ ZIP _____

If retired, former profession _____ Referred By _____ Marital Status _____

Spouse's Name _____ Social Security No. _____ Spouse's Birthdate _____

Spouse's Occupation _____ Employer _____ Years with firm _____

Employer's Address _____ City _____ ZIP _____

Person financially responsible _____ Relationship to you _____

Billing Address _____ City _____ ZIP _____

Your Physician _____ Phone _____ Dental Insurance ? _____

Former Dentist _____ Address _____

Your Children's names and ages _____

_____

_____

Your hobbies or special interests _____

Date of last dental visit _____

PLEASE CHECK THE APPROPRIATE "Yes" OR "No" BOX ON EACH QUESTION

	Yes	*No*
Do you prefer to save your teeth	☐	☐
Is your General health good	☐	☐
Were you given a local anesthetic	☐	☐
Were X-Rays given	☐	☐
Were home instructions given	☐	☐
Were regular preventive visits made	☐	☐
Was there a history of dental decay	☐	☐
Were there any special problems?	☐	☐

Is there a sensitivity in your mouth to .....

	Yes	*No*		*Yes*	*No*		*Yes*	*No*
Heat	☐	☐	Sweets	☐	☐	Chewing	☐	☐
Cold	☐	☐	Biting	☐	☐	Previous Injury	☐	☐

Do you have a history of .....

	Yes	*No*		*Yes*	*No*
Headaches	☐	☐	Mouth Breathing	☐	☐
Nail Biting	☐	☐	Clenching & grinding	☐	☐

Have you had.....

	Yes	*No*		*Yes*	*No*		*Yes*	*No*
Dental implants	☐	☐	Tonsils out	☐	☐	Mastoid/ear infection	☐	☐
Organ Transplant	☐	☐	Adenoids out	☐	☐	Measles	☐	☐
A recent physical exam	☐	☐	Anemia	☐	☐	Mumps	☐	☐
Any heart problems	☐	☐	Arthritis	☐	☐	Nephrosis	☐	☐
High blood pressure	☐	☐	Asthma	☐	☐	Rheumatic Fever	☐	☐
Circulatory problems	☐	☐	Cerebral Palsy	☐	☐	Scarlet Fever	☐	☐
Radiation treatments	☐	☐	Chicken Pox	☐	☐	Thyroid	☐	☐
Pain in region of ears	☐	☐	Chronic Sinus	☐	☐	Tonsilitis	☐	☐
Excessive bleeding	☐	☐	Diabetes	☐	☐	Tuberculosis	☐	☐
Bleeding gums	☐	☐	Epilepsy	☐	☐	Venereal Disease	☐	☐
Food collected between teeth	☐	☐	Hepatitis	☐	☐	A.I.D.S.	☐	☐
Fluoride treatments	☐	☐	Malignancies	☐	☐	Blood Transfusion	☐	☐
Tooth sensitivity tests	☐	☐						
Allergy to local anesthetics	☐	☐						
Allergy to antibiotics	☐	☐						
Any other allergies	☐	☐						
Joint replacement	☐	☐						
Orthopaedic surgery	☐	☐						

Please describe any current medical treatment, including drugs, impending operations, pregnancies, or other information the doctors should be aware of: _____

_____

_____

_____

_____

Signature _____

FOR PATIENTS WITH DENTAL INSURANCE

Insured person's name _____ Soc. Sec. No. _____

Insurance Company _____

Name of Employer _____ Group Plan No. _____

ASSIGNMENTS OF BENEFITS

I authorize payment of dental benefits to myself or the named Provider for professional services rendered.

Signed _____ Date _____

(Subscriber)

2001	**2007**
2002	**2008**
2003	**2009**
2004	**2010**
2005	**2011**
2006	**2012**