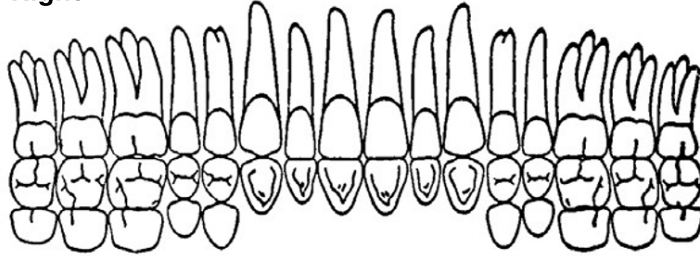


Dental Treatment Plan

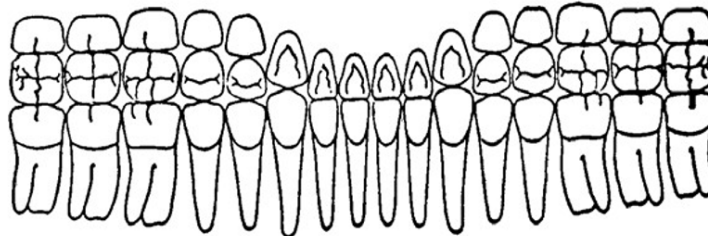
Name:	Date:
Sex:	Age:

Right



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

Left



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

Check one:		
Gingivia	<input type="checkbox"/> Normal	<input type="checkbox"/> Inflamed
	<input type="checkbox"/> Slight	<input type="checkbox"/> Highly inflamed
Deposit	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
Stain	<input type="checkbox"/> Slight	<input type="checkbox"/> Moderate
	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
Prosthesis present	<input type="checkbox"/> F/F	<input type="checkbox"/> P/P
Prosthesis needed	<input type="checkbox"/> F/F	<input type="checkbox"/> P/P
PSR Code	R:	L:
Head and neck exam (check one):		
Lips	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Buccal mucosa	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Pharynx	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Hard palate	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Soft palate	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Tongue	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Sublingual	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
TMJ	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Neck nodes	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

Dental Treatment Plan

Treatment plan		
Tooth number	Treatment	Remarks

Additional Notes