

Full Mouth Series (FMX)

Patient Information	
Name:	
Date of Birth:	
Gender:	
Address:	
Contact Number:	
Emergency Contact Name:	Number:
FMX Information	
Current Date:	
Reasons for Procedure:	
Additional Comments:	
_____	_____
Practitioner Name	Practitioner Signature
Date: ____/____/____	

FMX 18

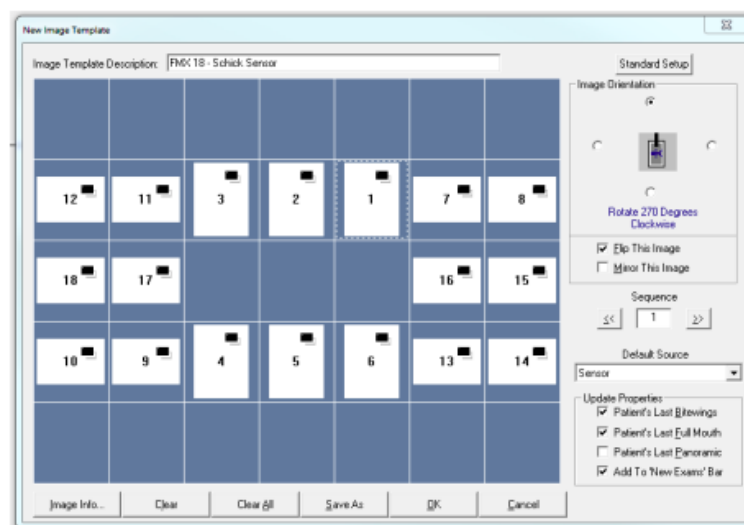


Image sourced from:
https://pattersonsupport.custhelp.com/euf/assets/Digital/Schick/Sensor_Templates/FMX_18_Template_08.05.2016.pdf?nointercept/1

Instructions: Using the image above, plot the information relevant to each section in the table below.

Section number	Name of tooth	Teeth	Additional notes
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			

Additional comments (include referrals for further procedures and diagnoses):

Practitioner name

Practitioner signature

Date: ____/____/____

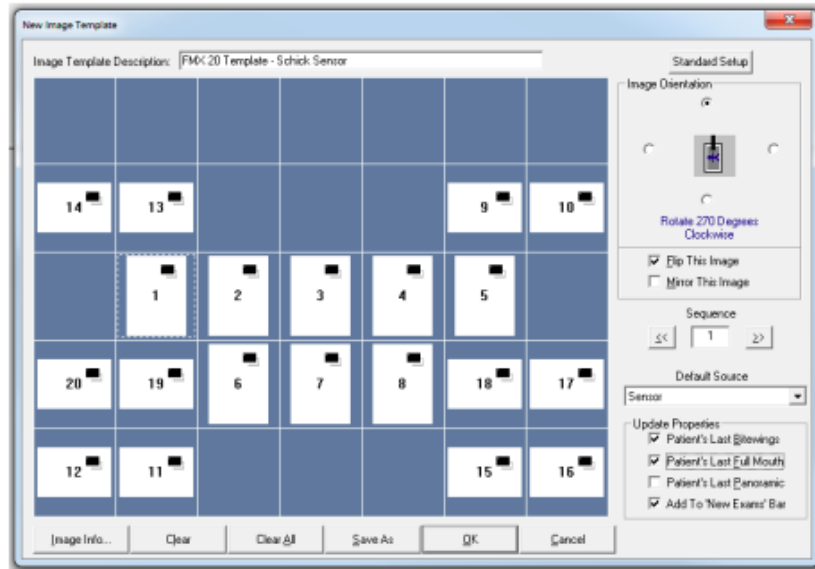


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