Oral Health Assessment

Clinic/Hospital Information	
Name:	
Address:	
Contact Number:	
Dentist/Oral Health Practitioner:	
Date of Assessment:	
Time of Assessment:	
Patient Information	
Name:	
Age:	Gender:
Date of Birth:	
Patient ID:	
Contact Information:	
Medical History	
Current Medications:	
Past Medical History:	
Allergies (Medication/Food):	
Family History of Dental Diseases:	
Dental History	
Last Dental Visit:	
Previous Dental Treatments (Fillings, Extractions, etc.):	
Current Dental Concerns:	

Lifestyle Habits
Tobacco Use: ☐ Yes ☐ No If yes, type:
Alcohol Consumption: ☐ Yes ☐ No
Dietary Habits (High in sugar, etc.):
Oral Hygiene Practices (Brushing, Flossing):
Oral Examination
1. Soft Tissue Examination
Lips, Cheeks, Floor of Mouth, Palate, Oropharynx:
Observations:
2. Gum and Bone Health
Gingival Condition:
Periodontal Screening (Bleeding, Pocket Depths):
3. Teeth Examination
Missing Teeth:
Caries:
Restorations (Fillings, Crowns):
4. Occlusion and TMJ Assessment
Bite Alignment:
TMJ Function:
5. Oral Hygiene Status
Plaque and Tartar Levels:
Oral Hygiene Practices:
6. Saliva and Hydration
Saliva Flow: ☐ Normal ☐ Reduced
Signs of Xerostomia (Dry Mouth): ☐ Yes ☐ No
7. Oral Cancer Screening
Visual Inspection:
Palpation of Oral Tissues:
Radiographic Examination
Type of X-rays Taken:

Findings:
Assessment and Diagnosis
Preliminary Diagnosis:
Risk Factors Identified:
Treatment Plan
Immediate Needs:
Long-Term Oral Health Goals:
Recommended Treatments:
Preventive Measures:
Patient Education
Oral Hygiene Instructions:
Dietary Recommendations:
Tobacco and Alcohol Use Counseling:

Consent for Treatment

I, [____________________________], hereby consent to the proposed dental treatment plan.

Patient's Signature: **Date:**

Dentist's Signature: **Date:**