Date	Treatment	N.V.	Prod.	PMT	Bal

Michael Goodman, O.D.
General Dentistry

Dentist ______________________

Phone ______________________

Name ______________________ Date of Birth ______________________

Address ______________________ City ______________ Phone ______________

Employed By ______________________ Off. Phone ______________

Physician ______________________ Phone ______________

Insurance ______________________

Medical Alert:

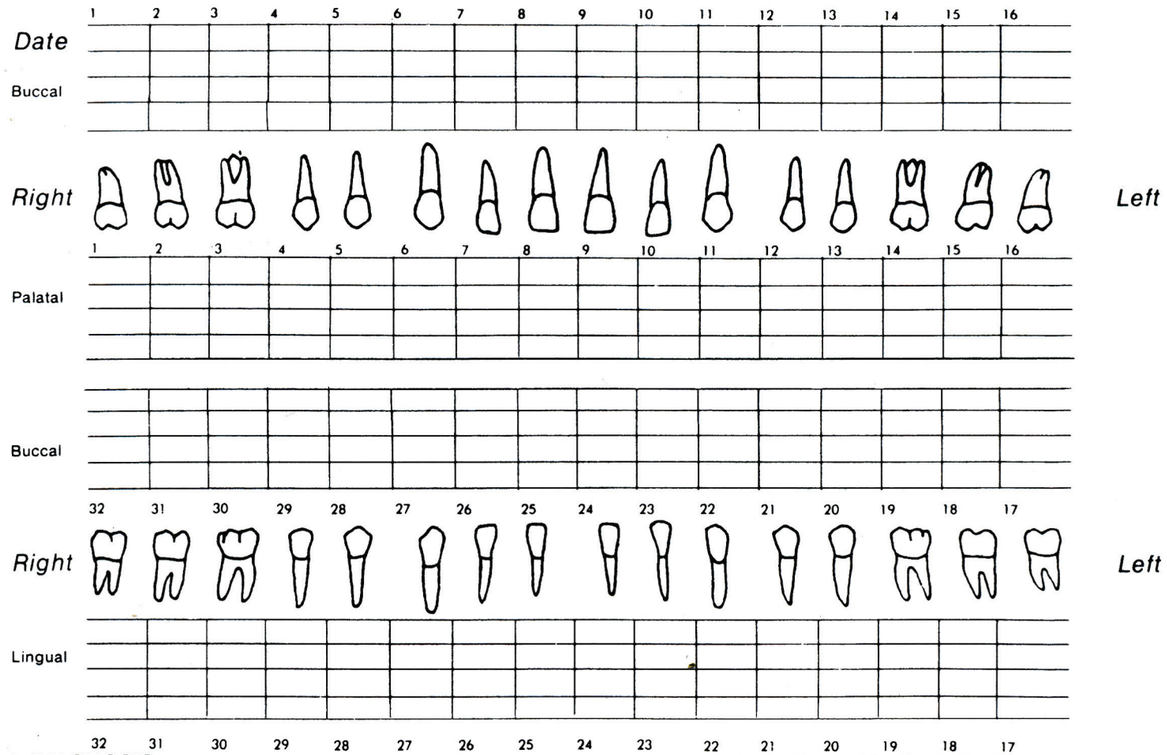
Thank you ________

X-Rays & Report ________

Init. Therapy Complete ________

Tx Complete (Restorative suggestions) ________

Date	Treatment	N.V.	Prod.	PMT	Bal



I DIAGNOSIS

(1) ☐ Incipient ☐ Moderate ☐ Advanced ☐ Terminal — ☐ Gingivitis ☐ Periodontitis ☐ ANUG — With localized areas of ☐ Moderate ☐ Advanced ☐ Terminal Disease.

(2) ☐ Posterior bite collapse

(3) _____ trauma from occlusion.

Pertinent Medical History

II EXAMINATION

(1) **Pocket depths** range between _____ and _____ mm.

(2) **Mobility**

☐ None
☐ 1 _____
☐ 2 _____
☐ ½ _____
☐ 1½ _____
☐ 3 _____

(3) **Occlusion** Class 1 2 3 Mutilated _____

(4) **Fremitus**

Centric
☐ None
☐ 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

Lateral
☐ None
☐ 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

(5) **Interferences**

Working
☐ None
☐ 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

Non-Working
☐ None
☐ 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

(6) **Mucogingival Problems**

☐ None
☐ 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

(7) **Furcations:** ☐ None

#1 Class	1	2	3	M	D	B	1	2	3	M	D	B	1	2	3	M	D	B
#2 Class	1	2	3	M	D	B	1	2	3	M	D	B	1	2	3	M	D	B
#3 Class	1	2	3	M	D	B	1	2	3	M	D	B	1	2	3	M	D	B
#14 Class	1	2	3	M	D	B	1	2	3	M	D	B	1	2	3	M	D	B
#15 Class	1	2	3	M	D	B	1	2	3	M	D	B	1	2	3	M	D	B
#16 Class	1	2	3	M	D	B	1	2	3	M	D	B	1	2	3	M	D	B

#17 Class	1	2	3	B	L		1	2	3	B	L							
#18 Class	1	2	3	B	L		1	2	3	B	L							
#19 Class	1	2	3	B	L		1	2	3	B	L							
#30 Class	1	2	3	B	L		1	2	3	B	L							
#31 Class	1	2	3	B	L		1	2	3	B	L							
#32 Class	1	2	3	B	L		1	2	3	B	L							

(8) **Teeth**

☐ Missing
1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

☐ Malposed
1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

☐ Fanning
1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

☐ Need for Endo
1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

☐ Caries ☐ Rampant
1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

Oral Hygiene

Stain:	Heavy	Moderate	Light
Dis. Sol ☐			
Brush ☐			
Rubber Tip ☐			
Floss ☐			
Proxa-Brush ☐			
Perio-Aid ☐			

(9)	**Soft Tissue**	☐ Edematous	☐ Fibrotic	☐ Fibroedematous
(10)	**Oral Hygiene**	☐ Poor	☐ Fair	☐ Good
(11)	**Plaque**	☐ Light	☐ Moderate	☐ Heavy
(12)	**Calculus**	☐ Light	☐ Moderate	☐ Heavy

(13) **Bone Loss** ☐ Generalized _____ % ☐ Localized to _____ %

III PROGNOSIS

☐ Excellent _____ ☐ Fair _____ ☐ Questionable _____ ☐ Hopeless _____

DIAGNOSTIC SERVICES	FEE	DATE
☐ 0110 Periodontal Exam		
☐ 0210 Full Mouth Radiographs		
☐ 0220 Single Radiograph		
☐ 0230 Radiographs, Add Films # of films _____		
☐ 9920 Treatment Planning Consultation		
☐ 0470 Diagnostic Casts		
☐ 0440 Biopsy		
☐ _____		
☐ _____		
PRE-SURGICAL SERVICES		
☐ 1340 Plaque Control		
☐ 4340 Perio Scale & Root Plane whole mouth 1 visit		
☐ 4341 Perio Scale & Root Plane by quadrant w/ anesthesia.		
☐ upper right		
☐ upper left		
☐ lower right		
☐ lower left		
☐ 4220 Gingival curettage with local anesthesia by quadrant.		
☐ upper right		
☐ upper left		
☐ lower right		
☐ lower left		

	FEE	DATE
☐ 4330 Limited Occlusal adjustment		
☐ 4331 Occlusal adjustment complete		
☐ 4350 Tooth movement _____		
☐ 4360 Periodontal Appliance _____		
☐ 4320 Intracoronal Stabilization UA UR UL LA LR LL NOTE: only circled sextants to be done.		
☐ 4321 Extracoronal Stabilization UA UR UL LA LR LL		
POST SURGICAL SERVICES		
☐ 0120 Periodic Oral Exam		
☐ 4910 Periodontal Prophy		
☐ 9430 Office Visit		
☐ 1210 Topical Fluoride		
☐ 9910 Desensitization		
☐ _____		
SURGICAL SERVICES		
☐ 4260 Osseus surgery by sextant		
☐ upper anterior		
☐ upper right		
☐ upper left		
☐ lower anterior		
☐ lower right		
☐ lower left		

	FEE	DATE
☐ 4350 Root Resection Tooth # _____		
☐ 4271 Free gingival graft by sextant		
☐ upper anterior		
☐ upper right		
☐ upper left		
☐ lower anterior		
☐ lower right		
☐ lower left		
☐ 4270 Pedicle graft Tooth #'s _____		
☐ 4210 Gingivectomy by sextant		
☐ upper anterior		
☐ upper right		
☐ upper left		
☐ lower anterior		
☐ lower right		
☐ lower left		
☐ 7960 Frenectomy Tooth # _____		
☐ 4261 Bone graft Tooth # _____		
☐ 7110 Extraction Tooth# _____		
☐ _____		
☐ _____		

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

▶ _____
SIGNED (PATIENT, OR PARENT IF MINOR) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

▶ _____
SIGNED (INSURED PERSON) DATE

RESTORATIVE Tx

Ortho.:

By:

Misc.