

5 5.3 Existing Oral Conditions and Services Needed

cont'd

FACIAL
 MAXILLARY
 LINGUAL
 LINGUAL
 MANDIBULAR
 FACIAL

LEGEND

- Missing Teeth** "X" out missing teeth
- Restoration** Black in area
- Replacements** Sketch area of replacement and state "fixed" or removable"
- Endodontics** Draw line in appropriate canal(s)
- Fractures** Black out missing portion, or fracture line
- Pathology** (abscesses, cysts, etc.) Sketch in at location and label
- Caries** Circle area on tooth surface

5.4 Prosthesis Evaluation: _____

6 REVIEW OF HISTORY AND CLINICAL EXAMINATION

6.1 Tests and Referrals: _____

6.2 Comments: _____

7 TREATMENT PLAN and ESTIMATE	

8 CONSENT TO THE TREATMENT PLAN

The Treatment Plan recorded above and alternatives have been described to me. I fully understand the risks, benefits and alternatives of the recommended treatment. All my questions have been answered.

Signature _____ Date ____ / ____ / ____
 (If a minor, parent or guardian must sign)

