Printable Dental Examination Form

Patient information	
Name:	**Date of birth:**
Contact number:	**Date of exam:**
Address:	
Medical history	
Existing medical conditions:	
Current medications:	
Allergies:	
Dental history	
Date of last dental exam:	
Last X-rays taken:	
Any dental concerns or pain:	

Examination findings	
Teeth examination	**Gums and soft tissue**
Cavities detected: ◯ Yes ◯ No	Signs of inflammation: ◯ Yes ◯ No
Number of cavities:	Bleeding on probing: ◯ Yes ◯ No
Condition of existing fillings:	Gum pocket depths:
Occlusion and jaw	**X-rays**
Signs of grinding or clenching: ◯ Yes ◯ No	X-rays taken: ◯ Yes ◯ No
TMJ condition:	Findings:
Dentist’s notes	
Dentist’s name:	**Signature:**