☐ **Monsey Family Medical Center**
40 Robert Pitt Drive
Monsey, NY 10952
845-352-6800
Fax 845-352-7292

☐ **Dental Care on Wheels**
40 Robert Pitt Drive
Monsey, NY 10952
845-352-6800
Fax 845-352-7292

(TO BE FILLED OUT BY PATIENT)

DATE: ______________________________

PATIENT NAME_____________________________________ DATE OF LAST VISIT TO A DENTIST: _______________

REASON FOR COMING TO DENTIST TODAY: ____

DO YOU HAVE ANY DENTAL PROBLEMS THAT YOU ARE AWARE OF? ☐ YES ☐ NO

IF YES, DESCRIBE: ____

HAVE YOU EVER HAD:

1. A BAD REACTION TO A DENTAL INJECTION? ☐ YES ☐ NO
2. FAINTING SPELL/DIZZINESS ☐ YES ☐ NO
3. ABNORMAL BLEEDING ☐ YES ☐ NO
4. BLEEDING GUMS ☐ YES ☐ NO
5. FOOD CATCHING BETWEEN TEETH ☐ YES ☐ NO
6. SENSITIVITY TO HOT/COLD ☐ YES ☐ NO
7. SORES IN MOUTH ☐ YES ☐ NO
8. JAW PROBLEMS: GRINDING TEETH, “CLICKING”, SORE JAW MUSCLES ☐ YES ☐ NO

PATIENT OR GUARDIAN’S SIGNATURE:_____________________________________ DATE: __________________

(TO BE FILLED OUT BY CLINICIAN)

SOFT TISSUE EVALUATION

1. LIPS _______________________________________
2. TONGUE ___________________________________
3. ORAL MUCOSA _____________________________
4. HARD PALATE ______________________________
5. SOFT PALATE ______________________________
6. FLOOR OF MOUTH __________________________
7. OTHER _____________________________________

RADIOLOGICAL EVALUATION

PERIODONTAL: _________________________________

VERTICAL BONE LOSS: ___________________________

HORIZONTAL BONE LOSS: ________________________

BONY:

PERIAPICAL PATHOLOGY: ________________________

OTHER: _______________________________________

CARIES: ______________________________________

0: Normal
1: Bleeding Present
2. Calculus and/or defective margins present
3: Pockets up to 5mm present
4: Pockets 5.5mm or greater
*: Other abnormalities present

<u>TREATMENT PLAN</u>

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