1440 FM 2931 Ste B, Aubrey, TX 76627
Office: (940) 365-9600 Fax: (877) 747- AVID (2843)

DENTAL EXAMINATION

Date:		Physician:	
Physician Phone #:		Physician Address:	

Consumer and Case #:	
Date of Birth and Age:	
Medicaid and Medicare #'s:	
Current Medications:	
Allergies:	

Was premed given? Please Check	YES	NO
Specify (Please Check)	ANTIBIOTIC	SEDATIVE

Services Completed: (Please check below)	Individual Has: (Please check below)
EXAM	OWN TEETH
CLEANING	PARTIAL-upper lower
X-RAYS	DENTURE-full upper lower

Comments (general hygiene): _____

Is any other work necessary? (Please check) YES _____ NO _____
(Please explain) _____
_____

Dentist recommended return date: _____
Please check: 6 months _____ 1 year _____ other _____
Date of next exam: _____

_____ _____
Physician's Signature Date