Patient Name: ______________________________DOB:______________Date: _____

Dentures: __Yes ___No Age of Dentures __________Upper ___Lower_________
Crown: ______________First Placement________________

EXISTING CONDITION ___TX PLAN 1 _____REASON _______TXPLAN 2_____

1.____
2.____
3.____
4.A____
5.B____
6.C____
7.D____
8.E____
9F____
10.G____
11.H____
12.I____
13.J____
14____
15____
16____
17____
18____
19____
20.K____
21.L____
22.M____
23.N____
24.O____
25.P____
26.Q____
27.R____
28.S____
29.T____
30____
31____
32____

NOTES
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