Dental Evaluation

Box must be filled out completely by person attending with client.

Name: _____ Date of Appt: _____ Time of Appt.: _____

Facility: _____ Physician/Providers Name: _____

Ariel Staff Present: _____

To be completed by dentist:

		YES	NO
1.	Are there any decayed teeth?	_____	_____
2.	Is the gum tissue normal?	_____	_____
3.	Do the teeth show evidence of proper brushing?	_____	_____
4.	Is there obvious infection?	_____	_____
5.	Are further X-rays needed?	_____	_____
6.	Should straightening of the teeth be considered?	_____	_____
7.	Are other abnormalities present other than malocclusion?		_____ _____
8.	Did the patient arrange for necessary treatment?	_____	_____

Comments & Recommendations:

_____

_____

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Signature of Evaluator: _____ Date: _____