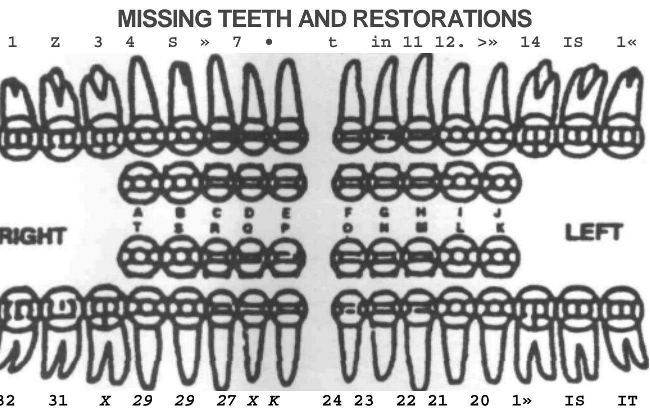
PT. **NAME**

Dental Group

NEW RESTORATIONS REQUIRED

RIGHT UNGUAL LEFT

MISSING TEETH AND RESTORATIONS



EXISTING CONDITIONS ______________________________

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55SSE	REASON FOR Replacement	
ORTHO REFERRAL?	NORMAL TMJ	☐YES ☐NO
PERIO REFERRAL?	NORMAL SOFT TISSUE?	☐YES ☐NO
ORAL SURGERY REFERRAL?	NORMAL BONE?	☐YES ☐NO
ENDO REFERRAL?	NORMAL GLANDS?	☐YES ☐NO
	NORMAL NECK?	☐YES ☐NO
Medical Alert		

Service Completed	Tooth No	Surface	Service Necessary		Ins Copy Prr			Comments

I herby accept all diagnosed dental procedures listed above for myself, spouse or child. If I decided to proceed with treatment, I also acknowledge the additional charge(s) noted above for optional treatment not covered by my dental plan.

Responsible party signature______________________________