PRELIMINARY PATIENT DENTAL CARE
NEEDS ASSESSMENT

Patient Information **Date of Assessment: _____**
Patient Name: _____ Age: _____ Dentsyst #: _____
Available: (check): ☐ M ☐ T ☐ W ☐ Th ☐ F
Home Phone: _____ Work Phone: _____

SPECIFIC AREAS OF NEEDED DENTAL CARE

URGENT CARE:
☐ Deep Caries ☐ Amal. Core ☐Dent. Rep. ☐Interim PD
☐Fract. Tooth ☐ Other

PERIODONTICS:
☐ Class I ☐ Class II ☐ Class III ☐ Class IV

ORAL SURGERY:
☐ Urgent ☐ Surgical ☐ Biopsy ☐ Pre-Prosth.

ENDODONTICS:
☐ Urgent ☐ Caries Control ☐ Single Root ☐ Multi Root

GENERAL DENTISTRY:
☐ Anterior Caries ☐ Posterior Caries ☐ Simple TP ☐ Complex TP

FIXED PROSTHODONTICS:
☐ Ant. Crowns ☐ Post. Crowns ☐ Ant. Bridge ☐ Post. Bridge

REMOVABLE PROSTHODONTICS: U=UPPER L=LOWER B=BOTH
☐ Reline ☐ Repair ☐ Complete ☐ Partial

ORTHODONTICS:
☐ Space/Crowding ☐ Crossbite ☐ Tipped Abutment ☐ General

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THE ABOVE WERE CHECKED: ☐ WITH RADIOGRAPHS ☐ WITHOUT RADIOGRAPHS

Comments/Special Management of Patient: _____

_____

_____

Initial Case Disposition

- **Assign to:**
  Pre-Doctoral Clerkship Postgraduate Endo ONLY
  Ortho ONLY AEGD SPC
- **Assign to Oral Surgery first, then: _____**

Final Case Disposition

- **Assign to: _____ Dentsys: _____ GP: _____**

SIGNED: _____ DATE: _____

Revised 10/01/94 mfr 01.03011