PERIODONTAL EVALUATION

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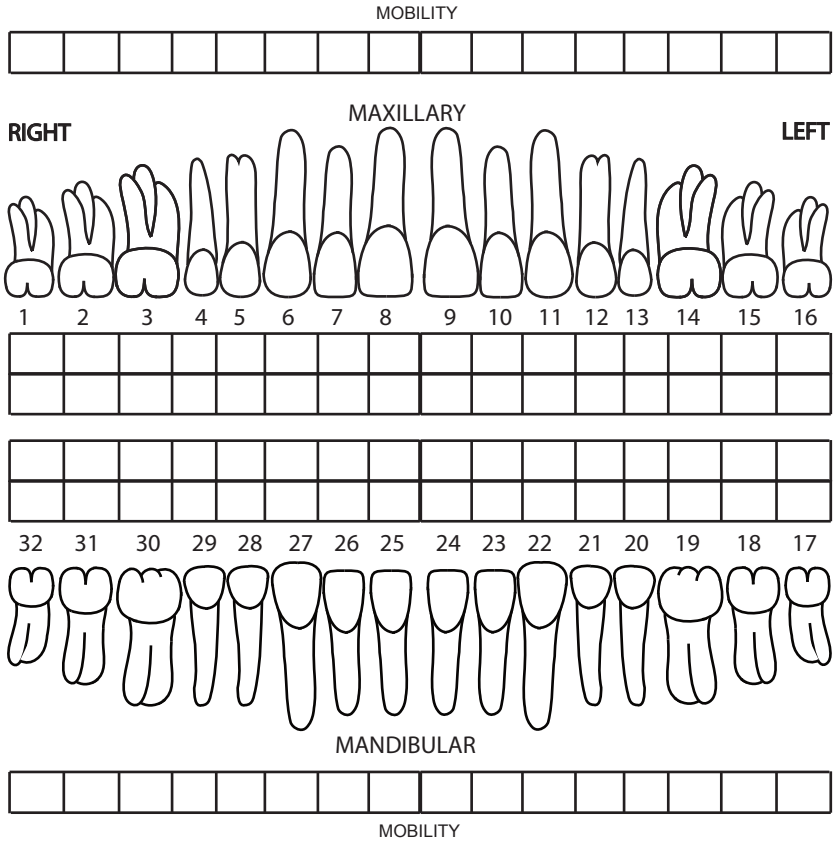
Date _____ Dentist's Name_____

Insurance_____ SS# (ID)_____



MOBILITY GRADES

0 NORMAL
+1 FACIAL-LINGUAL-IMM.+
+2 MECIAL-DISTAL-IMM.+
+3 BOTH-1 AND + 2

CALCULUS ACCUMULATION

☐ LIGHT
☐ MODERATE
☐ HEAVY

(Denote teeth number, where applicable)

GINGIVAL CONDITION:
☐ Localized ☐ Recession ☐ Fibrosis ☐ Mucogingival Defect
☐ Firm, Resilient ☐ Hyperplasia ☐ Cratering
☐ Suppuration ☐ Generalized ☐ Hemorrhage on probing
☐ Edema

RADIOGRAPHIC EXAMINATION:
☐ Localized ☐ Generalized
☐ Mild ☐ Moderate Severe

OCCLUSION:
☐ Stable &Non-Contributory ☐ Muscle Tenderness ☐ Fremitus ☐ Missing teeth
☐ Bruxism ☐ Centric Interference ☐ Clenching ☐ No Replacement
☐ Food Impaction ☐ Malpostioned ☐ Jaw Opening Deviation

DIAGNOSIS: ☐ I Gingivitis ☐ II Early ☐ III Moderate ☐ IV Advanced

GNOSIS: ☐ Favorable ☐ Guarded ☐ Poor ☐ Hopeless

ATTENDING DENTIST'S SIGNATURE:_____

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