FIRST ORAL EXAMINATION REPORT

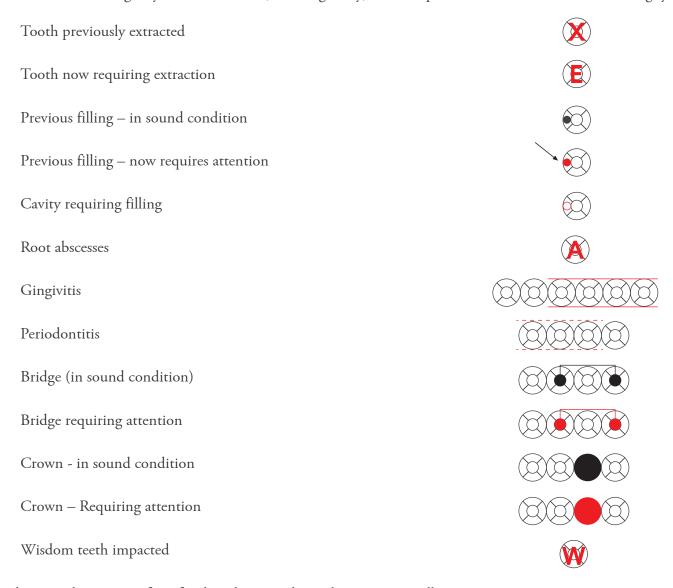


(All sections must be completed)

Name:	Date of Birth (day/month/yea	r):Sex:_
Examination Date (day/month/year):		
If group insurance, name of the Policyhold	ler:	
ECTION B – EXAMINING DENTIST'S RI	EPORT	
Have any dental X-ray been taken during If "Yes", please describe nature of X-ray		Yes □ No □
2. Please describe general condition of den	tures (if any):	
3. Other abnormalities or observations: Ple	rase specify	
4. Diagramatic Report:		
	LABIAL	
RIGHT	LINGUAL	LEFT
	LABIAL COCO	
Name of Dentist:		
Address:		
Telephone No.:		Signature of Dentist
E-mail:	Date (day/mon	th/year):

Examination Reporting Code:

1. Please record finding of your examination (including X-ray) on the report from overleaf with the following symbols:



2. Please mark position of artificial teeth currently on dentures as per illustration.

