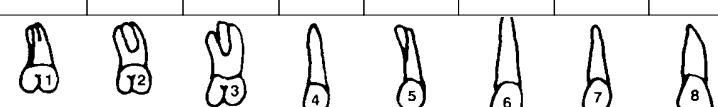
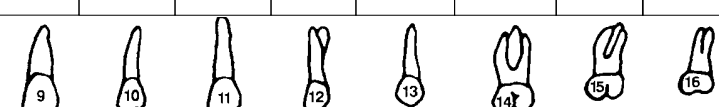
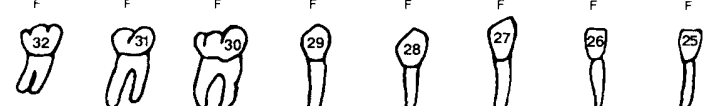
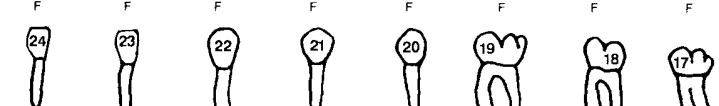


DATE	DENTAL OFFICE NUMBER	DENTIST'S NAME	
PATIENT'S NAME		BIRTH DATE	ADDITIONAL INSURANCE
SUBSCRIBER		SOCIAL SECURITY NUMBER	
IS THIS A FIRST TIME TREATMENT FOR THIS CONDITION? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF NO, WHEN TREATED?	

WHAT TYPE OF TREATMENT?

MOBILITY																									
																									
D M D M D M D M D M D M D M D M								M D M D M D M D M D M D M D M D M D M																	
L L L L L L L L								L L L L L L L L																	
RIGHT								LEFT																	
																									
D M D M D M D M D M D M D M D M								M D M D M D M D M D M D M D M D M D M																	
L L L L L L L L								L L L L L L L L																	

### MOBILITY

<b>CHARTING SYMBOLS &amp; INSTRUCTIONS</b> (x) = Missing Tooth      SP = Suppuration / = Tooth to be Extracted         = Open Contacts ▲ (Grade), Furcation Involvement      • = Bleeding Point (▲) = Periapical Involvement	<b>MOBILITY GRADES</b> 0 Normal +1 Facial-Lingual-Imm. + +2 Mesial Distal Imm. + +3 Both +1 and +2
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**CALCULUS ACCUMULATION**       Light       Moderate       Heavy

**GINGIVAL CONDITION (Denote Quadrant: UL, UR, LL, LR)**

<input type="checkbox"/> Localized	<input type="checkbox"/> Edema	<input type="checkbox"/> Mucogingival Defect.	<input type="checkbox"/> Hyperplasia
<input type="checkbox"/> Generalized	<input type="checkbox"/> Suppuration	<input type="checkbox"/> Recession	<input type="checkbox"/> Cratering
<input type="checkbox"/> Firm, Resilient	<input type="checkbox"/> Hemorrhage on Probing	<input type="checkbox"/> Fibrosis	

**RADIOGRAPHIC EXAMINATION - Alveolar Bone Loss Is: (Denote Quadrant: UL, UR, LL, LR)**

<input type="checkbox"/> Localized	<input type="checkbox"/> Mild	<input type="checkbox"/> Vertical
<input type="checkbox"/> Generalized	<input type="checkbox"/> Moderate	<input type="checkbox"/> Horizontal
	<input type="checkbox"/> Severe	

**OCCLUSION (Denote Quadrant: UL, UR, LL, LR)**

<input type="checkbox"/> Stable and Non-Contributory	<input type="checkbox"/> Muscle Tenderness	<input type="checkbox"/> Centric Interference
<input type="checkbox"/> Missing Teeth No Replacements	<input type="checkbox"/> Bruxism	<input type="checkbox"/> Jaw Opening Deviation
<input type="checkbox"/> Clenching	<input type="checkbox"/> Food Impaction	<input type="checkbox"/> Malocclusion

**DIAGNOSIS (Periodontal Case Type)**

<input type="checkbox"/> I. Gingivitis	<input type="checkbox"/> II. Slight Gingivitis	<input type="checkbox"/> III. Moderate Periodontitis	<input type="checkbox"/> IV. Advanced Periodontitis	<input type="checkbox"/> V. Refractory Periodontitis
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**PROGNOSIS**       Favorable       Guarded       Poor       Hopeless

ATTENDING DENTIST'S SIGNATURE \_\_\_\_\_