Patient's Name: _____

Address: _____

_____

Date of Examination: | | | |

Date Treatment Completed: | | | |

DENTAL CHART

5																		5
4																		4
3									RL									3
2																		2
1																		1
	8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8	
1																		1
2																		2
3									RL									3
4																		4
5																		5

Treatment carried out:

_____

_____

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Above should include a notation of Teeth already missing:

Signature: _____

DENTIST

AH2201