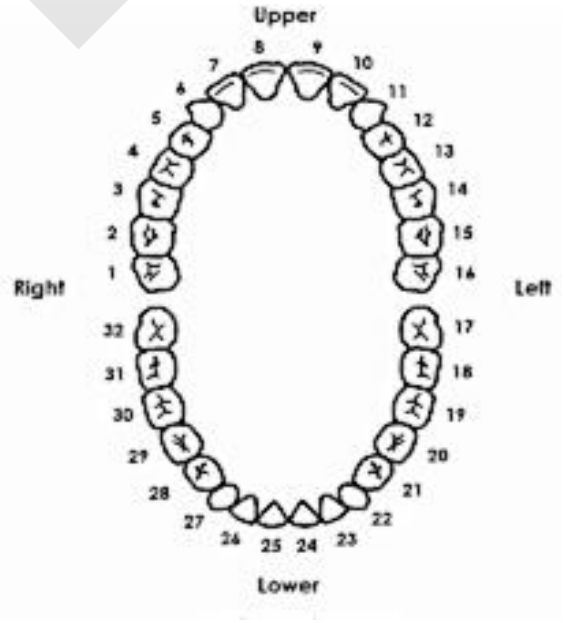
TREATMENT PLANNING

Patient Name _____ **Date** _____ **Clinician Name /#** _____

ASSESSMENT	Appt. 1	Appt. 2
Health History, EOIO		
Dental Charting		
PSE		
OHI		
Tx Plan, Risk Assessment		

CONCERNS NEEDING TREATMENT MODIFICATION:				
Health History	**EOIO**	**Dental Charting**	**PSE**	**Culturally Diverse**
Latex allergy	Mouth sores	Composites or resin margins	Sensitivity to probing	
Anxiety		Decalcification	Areas of recession	**Medically Complex/Special Needs**
Non-verbal clues		Cement/crown margin	Greater than minor bleeding	

PROCEDURES	Appt 1	Appt 2	Appt 3	Appt 4	Appt 5	Appt 6
Radiographs						
NSPT tooth #s or quads						
Anesthesia						
Selective Polishing						
Adjunctive Procedures						
Fl2 Varnish tooth #s						
Sealants						
Desensitizing						
Subgingival irrigation						



The treatment plan outlined above has been explained to me, and my questions have been answered. I understand the importance of completing my treatment and the time that has been set aside to do this.

_____ _____ _____

Patient Signature Date Faculty Signature

Areas/Teeth excluded from treatment noted above with red dot. Initial below indicating it is understood the above area(s) will not be included in treatment plan.

Patient initials Faculty DDS

4/15 KP