Prairie State College
Dental Hygiene Program

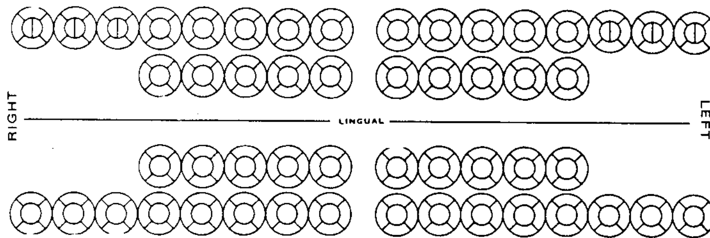
DENTAL EXAMINATION FORM

To the Applicant: *Please complete and return to the Dental Hygiene Department prior to the beginning of classes.*

STUDENT'S NAME ______________________________ DATE __________
last *first* *middle*

ADDRESS ______________________________

CITY AND STATE ______________________________ ZIP CODE __________



ORAL HYGIENE:

Condition of teeth: __________
Condition of mucosa: __________
Inflammation present: __________
Color of gingiva: __________
Last full series radiographs: __________
Were fluoride treatments given: __________
Date of previous dental visit: __________
Is orthodontia indicated: __________
Date completed: __________

Have missing teeth been replaced: __________
a. by orthodontia: __________
b. by fixed bridgework: __________
c. by removable partial: __________
d. by full denture: __________
e. by implants: __________
Type of occlusion: ☐ normal ☐ abnormal
Dental work completed: ☐ yes ☐ no
Date completed: __________
Have you bleached your teeth ☐ yes ☐ no
Have you experienced any difficulty with local
anesthetics? ☐ yes ☐ no
nitrous oxide? ☐ yes ☐ no
Explain: ______________________________
____

Dentist's Signature: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Office Phone Number: (____) ______________________________

Key:
Missing teeth - Blue X
Dental Caries - Red
To be extracted - Red X
Impacted - IMP
Restorations - Blue
Pontics _______