Form (to be filled by the patient/user)

1.what dental problem you're currently facing?

Text box=

2.since how long are you facing the problem?

1. One week, b) more than two weeks

3.how frequently are you facing dental problems?

a)often b)regularly c) sometimes

4.have you taken any treatment for the problem?

Yes- tell us about it

No

4.Are you under any medications?

Yes , name it

No

5.Have you been hospitalized/operated? yes/no

5.Do you have any of the below ?

Blood pressure **( create boxes for ticking)**

Asthma ,

Gastritis,

Neural ,

Hepatic (liver),

Renal (kidney problems) ,

Diabetes,

Allergy

Upload pictures as instructed

Report generated by dentist:

Patient name: text=

Age:text=

Gender: text=

Medical history: text=

Dental history:text=**Findings from pictures:**

Stains: options= +, ++,+++ Calculus:+, ++,+++

**1)Gum health:** a.Gingivitis: options :present/ absent

b. Oral hygiene: good/ excellent/ fair/ poor

c. Gum recession: absent ,class 1/ 2/3/4

**2)Teeth health**

a)Tooth decay:

PRESENT=== TEXT

ABSENT

b)Root stumps: same

c)Tooth wear: absent/ attrition/ abrasion / abfraction/erosion

e)Any missing tooth: present== text

absent

f) Any non vital tooth: present== text

Absent

g)3 Teeth alignment:

a) Crowding : absent/ present w.r.t lower anterior/ upper anterior.

Left lower posterior region/ left posterior upper region

Right posterior upper region/ right posterior lower region

1. Spacing: same options as above

**3) Please mention if any other emergency finding: text===**

**Diagnosis:** text

**Treatment plan:** a)PREVENTIVE MEASURES: text

b)precautions:

c)patient referral:

Dr. name :

Reg id: