METRO ORAL SURGERY EXAMINATION

Date:_____ Name:_____Age:_____

BP:_____P:_____Wgt:_____Hgt_____

ASA Class I II III IV

Subjective:

Objective:

TMJ: Clicking? oNo oYes Pain? oNo oYes TX?_____

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

R		A	B	C	D	E	F	G	H	I	J		L
		T	S	R	Q	P	O	N	M	L	K		

Perio status: oGood oGingivitis oRecession oPeriodontitis oPockets oAttached ging. Deficiency

Assessment: oImpacted teeth oPericoronitis oInfection oMyofacial Pain Dysfunction oTM Dysfunction oSkeletal Deformity oCaries oOther_____

Discussed: oAnesthesia oNPO/Ride oBC Pill/antiobiotic RX oDry socket oBooklet/Video oSigned Consent oPre-op Instruct. oNVB/Sinus/root tip oImplants/Integration

Plan: Anesthesia: oLA oOral Premed oN2O oIV Sed oGen Time: 30 45 60 _____

TX Options:

Allergies_____

Clearance_____

Implant Dx_____

Implants Parts Only_____

Correspondence: oLetter to _____oCopy Pano oCopy PA oPath Report

Prosthetics_____ Doctor's Initials_____

Asst's Initials_____