DENTAL RECORD
FOR DENTAL HYGIENE STUDENTS
COLLEGE OF SOUTHERN IDAHO

To be completed and signed by your Dentist. (Form should be given Back to student-patient)

NAME________________________________________ DATE_________________

Please check one of the following:

Oral Hygiene:
- Good □
- Fair □
- Poor □

Calculus Deposits:
- Slight □
- Moderate □
- Heavy □

Periodontal Disease:
- General □ Mild □ Moderate □
- Severe □ None □

Examination and Treatment:

<table>
<thead>
<tr>
<th>DATE</th>
<th>TOOTH NUMBER</th>
<th>SERVICES - INCLUDE SURFACES AND TREATMENT</th>
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Dentist Signature: __________________________________________

Date: ________________________