

## IMPLANT CONSULTATION AND ASSESSMENT

### PATIENT INFORMATION

Name  Date

Address  D.O.B.

Home Phone

Post Code  Work Phone

Referred by  Mobile

### PATIENT C/O

### RELEVANT MEDICAL HISTORY

Smoking  Yes  No Consumption  /day

Diabetes  Yes  No

Regular attendee  Yes  No Sees Hygienist  Yes  No

TMJ  R  L  Gape

Smile Line  High  Average  Low Buccal Corridors

Family History of Periodontal Disease  Yes  No Oral Hygiene  Adequate  Inadequate

Soft Tissue Scan  Yes  No BPE

Biotype  Thick  Thin \*Code 4 requires Full Perio Assessment

Scallop  High  Low Diagnosis

OCCLUSION  Vh  Hv

Skeletal Class  I  IId1  IId2  III RCP

Incisor Relationship  I  II  III Teeth in cross bite

GUIDANCE Left Excursion  Right Excursion  Protrusive

PREMATURE CONTACTS Non-working side contacts  Yes  No

EVIDENCE OF BRUXISM  Yes  No TSL

NOTES

Three empty rounded rectangular input fields for notes.

TEETH RECOMMENDED FOR IMPLANT THERAPY

A rounded rectangular input field with a vertical line in the center, likely for a dental arch diagram.

\*options of denture/bridge/implant discussed

CAWOOD HOWELL	Class	<input type="radio"/> I	<input type="radio"/> II	<input type="radio"/> III	<input type="radio"/> IV	<input type="radio"/> V	<input type="radio"/> VI	Maxilla
		<input type="radio"/> I	<input type="radio"/> II	<input type="radio"/> III	<input type="radio"/> IV	<input type="radio"/> V	<input type="radio"/> VI	Mandible

SCAN REQUIRED

Siplant       Nobel Guide

RADIOGRAPHICS REPORT; CARIES/ENDO/PERIO

OPG

BW

PA

SINUS GRAFT

<input type="radio"/> Right	<input type="radio"/> Left		
<input type="radio"/> Autogenous	<input type="radio"/> Alloplastic	<input type="radio"/> Xenograft	<input type="radio"/> Allograft

CORTICO-CANCELLOUS BLOCK GRAFT

<input type="radio"/> Ramus	<input type="radio"/> Ant. Mandible	<input type="radio"/> Hip	<input type="radio"/> Allograft
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GUIDED BONE REGENERATION

<input type="radio"/> Autogenous	<input type="radio"/> Alloplastic	<input type="radio"/> Xenograft	<input type="radio"/> Allograft
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PROPOSED TREATMENT PLAN

1.
2.
3.
4.
5.
6.

TEMPORARY PROVISION

Denture

Rochette

Provisional Bridge	<input type="radio"/> All-Acrylic	<input type="radio"/> Acrylic Reinforced	<input type="radio"/> Metal Based
Immediate Load	<input type="radio"/> Standard	<input type="radio"/> All-on-4	<input type="radio"/> Nobel Guide