ABLE Residential
DENTAL EXAM FORM

Name: _____ **Date:** _____

Home Address: _____ **Dentist:** _____

Home Phone#: _____ **Dentist Phone#:** _____

Medications:

_____

_____

_____

_____

_____

Allergies:

_____

_____

Diagnosis:

_____

_____

Reason for Visit: _____

X-Rays Taken: ☐ **Yes** ☐ **No**

Remarks: _____

_____

_____

_____

_____

_____

_____

_____

_____

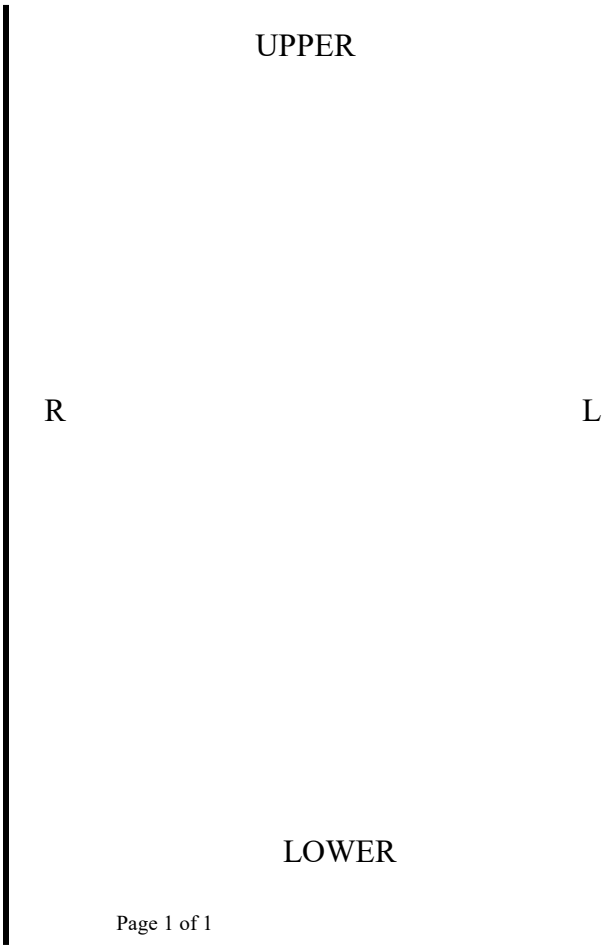
_____

_____

Date of Next Visit: _____

_____

Person Accompanying Individual **Title** **Date**

_____

Dentist Signature **Date**