PERIODONTAL TREATMENT FLOW CHART B U S

Patient No.:

Patient: _____ **Date:** _____

Health History/Medic Alert: _____

Blood Pressure: _____ Classification: I II III IV V VI VII VIII

Fee Quote: _____ Insurance: Y N: _____

Financial Arrangement: _____

Appt. Date	Periodontal Therapy	Quadrants	Sextants	Tooth #(s)	Clinician	Fees
	Periodontal Screening / Comprehensive Periodontal Charting					
	Dr. Examination					
	FMX BW PAN PA (X-rays)					
	Initial Diagonstic Therapy/Cosmetic Polish (IDT)					
	Co-Therapy/OHI/Intro/Perio Etiology/Pt.Brochure					
	1 Perio Therapy/Modified PT/Gingivitis Oral Irrigation/Anesthetic					
	2 Perio Therapy/Modified PT/Gingivitis Oral Irrigation/Anesthetic					
	3 Perio Therapy/Modified PT/Gingivitis Oral Irrigation/Anesthetic					
	4 Perio Therapy/Modified PT/Gingivitis Oral Irrigation/Anesthetic					
	5 Perio Therapy/Modified PT/Gingivitis Oral Irrigation/Anesthetic					
	6 Perio Therapy/Modified PT/Gingivitis Oral Irrigation/Anesthetic					
	7 Additional Perio Therapy:					
	8 Desensitizing Fluoride Treatment					
	9 6 Wk Therapy, Appt Evaluation/Dr. Exam					
	10 Other					
	11 CC/SPT: 4 Wk. 6 Wk. 8 Wk. 10 Wk. 12 Wk.					
	12 Total (Periodontal Treatment needed)					

Restorative Therapy-Priority ✔To be appointed

Date	Tooth #	Surface	Treatment	Units	Fees
	1				
	2				
	3				
	4				
	5				
Total (Restorative Treatment Needed)					

PeriodontalTherapy Notes

Tissue Texture: _____

Plaque: L M H Sup/Calc: L M H

BOP: L M H Sub/Calc: L M H

BOS: L M H Stain: L M H

SENS: L M H Ten/Calc: L M H

Extra Oral Exam: WNL Abn _____

Intra Oral Exam: WNL Abn _____

Occlusal Analysis: Grinds Y N S _____

Patient Motivation: P F G E _____

Co-Therapy RX: 5min. 10 min. 15 min. 20 min. 25 min. 30 min. _____

Tools RX: ❑ Toothbrush ❑ Dental Floss ❑ Rubber Tip ❑ Floss Threader ❑ Periodontal Aid ❑ Proxabrush ❑ Superfloss

Nutritional Intake: P F G E Vitamin Therapy: B Complex C/Bioflavonoid ❑ Oral Irrigator

Specialist Referral: _____

I understand my current periodontal diagnosis and I accept the above treatment plan.

Signed/Date _____

Notes: _____