

Futures Community Support Services, Inc.  
**DENTAL APPOINTMENT FORM / DENTAL HYGIENE PLAN**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Staff: \_\_\_\_\_

Dentist Name: \_\_\_\_\_

Location of Dental Appointment: \_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date of Dental Exam: \_\_\_\_\_

Procedures Completed:  Prophy  Exam  Oral Cancer Screening

If other, please describe: \_\_\_\_\_  
(Impressions, Cavities Filled, Periodontal Scaling, Extractions,  
Root Canal, etc.)

If cleaning and exam was not completed, please explain why

\_\_\_\_\_  
\_\_\_\_\_

Results of Initial Screening: \_\_\_\_\_

\_\_\_\_\_

Condition of teeth: \_\_\_\_\_

Current Method of Dental Hygiene: \_\_\_\_\_

\_\_\_\_\_

Recommended Method of Dental Hygiene: \_\_\_\_\_

\_\_\_\_\_

Frequency: \_\_\_\_\_

\_\_\_\_\_

Special Considerations: \_\_\_\_\_

If Individual is on medication known to cause dental problems, what are the instructions  
from dentist? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of next follow-up exam: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_ Date: \_\_\_\_\_