

Assessment of Teeth

Form 7

Surname _____

Forename _____

Age

Sex

For office use

D D M M Y Y

CHI Number

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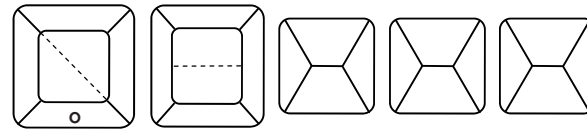
Examination Date

Day

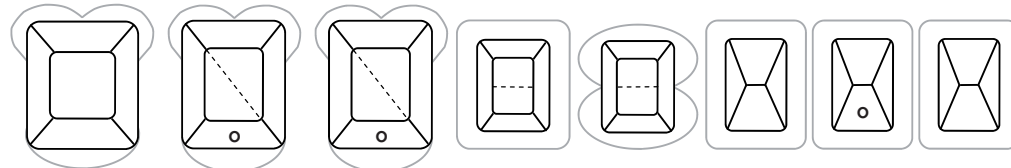
Month

Year

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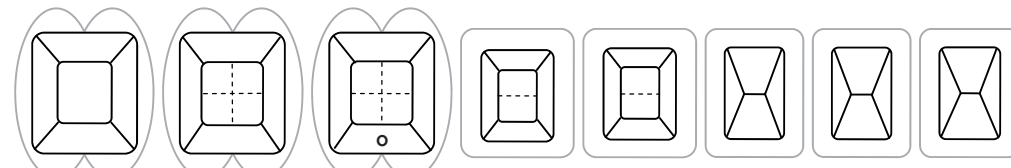


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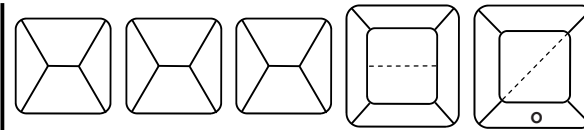
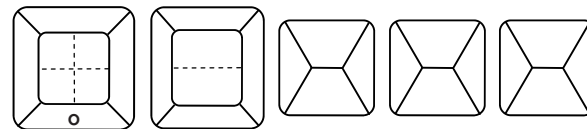
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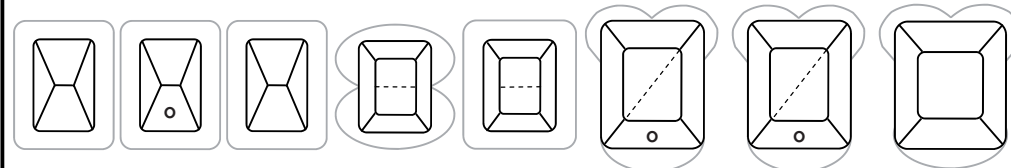


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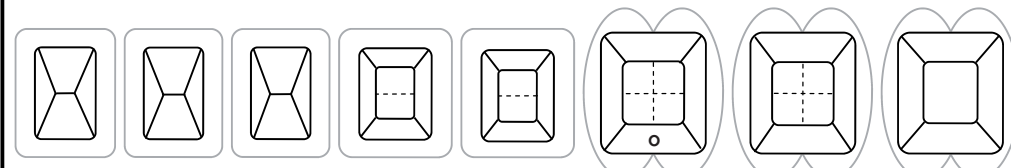


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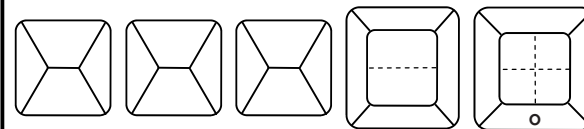


21 22 23 24 25 26 27 28

31 32 33 34 35 36 37 38



71 72 73 74 75



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Type of examination completed: Basic Full

Signature of Practitioner _____

Date _____