

Dental Examination Report – Adult

(Needs to be completed by applicant's dentist)

Please present this form to your treating/examining dentist for completion. A spouse, parent, sibling or child of the patient may not carry out the examination. Costs of the examination and reports are to be paid by the applicant.

Instructions to treating/examining dentist

Detailed dental examination is required in order that all questions listed below can be answered. If there are many „Yes“ responses to the questions listed below, or if otherwise clinically indicated, bitewing and panoramic (or diagnostic quality full mouth) radiographs should be performed. Please send the current and any previous x-ray reports together with this form.

I. Details of insured person (to be filled in by the applicant)

Name of policyholder			
Policy No.			
Name of insured person (patient)			
Date of birth		Sex	

II. Dental findings (to be filled in by the treating/examining dentist)

1. When did the patient last receive a dental treatment in your dental office or by a previous dentist?			Previous dentist									
2. Did the patient receive regular examinations or check-ups in the past three years?						☐ Yes ☐ No						
3. Have any dental x-rays been taken in the past or during this examination?						☐ Yes ☐ No						
If "Yes", please describe the nature and indication of the x-rays, mention the dates and send the previous and current x-rays to Foyer Global Health S.A.			Previous dentist(s)									
4. Who carried out the treatments/ examinations in the past three years? Name of current and previous dentist(s)/address/ e-mail/telephone number			Previous dentist(s) (may be filled in by the applicant)									
5. Present dental findings												
C = carious tooth												
F = missing tooth												
() = missing tooth, gap closed												
X = tooth requiring extraction												
E = Prosthesis												
T = Impacted tooth												
K = existing crown												
TK = existing partial crown												
IN = existing Inlay												
B = Pontic (Bridge)												
I = existing Implant												

Upper																
right								left								
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	FDI
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	FDI
Lower																

6.

Is there a dental caries (tooth cavity/decay) and/or insufficient filling which requires restoration?

☐ Yes
☐ No

If yes, which tooth/teeth?

7.

Is there a cracked or broken tooth which requires restoration?

☐ Yes
☐ No

If yes, which tooth/teeth?

8.

Is there a gingivitis or periodontal (gum) disease that requires treatment?

☐ Yes
☐ No

If yes, please provide us with the periodontal status or screening index.

9.

Are there functional complaints or illnesses to the jaw or occlusal relationship/malocclusion?

☐ Yes
☐ No

If yes, please use the section 22 for further details.

10.

Is there an existing old root canal filling, root abscess/ apical periodontitis or cyst that requires a root canal treatment, amputation or is further referral of the patient necessary or advisable?

☐ Yes
☐ No

If yes, which tooth/teeth?

11.

Does the patient clench or grind the teeth?

☐ Yes
☐ No

If yes, please use the section 22 for further details.

12.

Does the patient have tooth erosion, sensitivity, dental attrition or abrasion?

☐ Yes
☐ No

If yes, which tooth/teeth?

13.

Are there any existing dentures which requires removal, re-fabrication?

☐ Yes
☐ No

If yes, which tooth/teeth?

14.

Is there a history of cleft lip or cleft palate?

☐ Yes
☐ No

If yes, please use the section 22 for further details.

15.

Is there a hyperdontia, hypodontia or anodontia?

☐ Yes
☐ No

If yes, please use the section 22 for further details.

16.

Is there a history of orthodontic treatment, presently undergoing active orthodontic treatment or wearing retainer appliances?

☐ Yes
☐ No

If yes, please use the section 22 for further details.

17.

Please indicate on the chart the necessary and recommended restorations:

F = Filling

E = Prosthesis

K = Crown

TK = Partial crown

X = Extraction

B = Pontic (Bridge)

V = Veneer

IN = Inlay

I = Implant

Upper

right

18 17 16 15 14 13 12 11

21 22 23 24 25 26 27 28

1 2 3 4 5 6 7 8

9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25

24 23 22 21 20 19 18 17

48 47 46 45 44 43 42 41

31 32 33 34 35 36 37 38

left

FDI

FDI

Lower

18.

Is there an orthodontic treatment necessary or recommended?

☐ Yes
☐ No

19.

Is there a periodontal treatment necessary or recommended?

☐ Yes
☐ No

20.

Is there a wisdom tooth/teeth extraction necessary or recommended?

☐ Yes
☐ No

21.

Is there a bruxism/CMD/TMJ treatment necessary or recommended?

☐ Yes
☐ No

Dental Examination Report

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22. Other abnormalities, observations, remarks or necessary/recommended and planned treatments not previously mentioned (please specify).

Place and date of today's examination

(please sign and stamp)

Stamp

Signature of the treating/examining dentist with stamp and date