

Dental Charting Checklist Template

 Show only Checklist

Display Style
Default 

Patient Demographics Verification

Confirm accuracy of patient information before charting begins.

Patient First Name

Write something...

Patient Last Name

Write something...

Date of Birth

Write something...



Patient Phone Number

Enter a number...

Insurance Provider

- Aetna
- Cigna
- Delta Dental
- Blue Cross Blue Shield
- Other

Gender

- Male
- Female
- Other

Chief Complaint & History

Record patient's primary concern and relevant medical/dental history.

Chief Complaint (Patient's Words)

Write something...

Detailed History of Presenting Complaint

Write something...

Duration of Complaint (Days/Weeks)

Enter a number...

Relevant Medical History

- Diabetes
- Hypertension
- Heart Disease
- Allergies
- Medications
- Other (Specify)

Medications (List and Dosage)

Write something...

Date of Last Dental Visit

Enter date...

Reason for Visit

- Routine Checkup
- Emergency
- Restoration
- Cleaning
- Other

Extraoral Examination

Document observations of the face, lymph nodes, temporomandibular joints (TMJs), and occlusal forces.

Patient Name

Write something...

Chief Complaint (Extraoral Perspective)

Write something...

TMJ Assessment (Left)

- Normal
- Clicking
- Popping
- Crepitus
- Pain
- Limited ROM

TMJ Assessment (Right)

- Normal
- Clicking
- Popping
- Crepitus
- Pain
- Limited ROM

Neck Circumference (cm)

Enter a number...

Observations - Skin/Lymph Nodes

Write something...

Intraoral Examination - Soft Tissues

Assess and record findings related to the lips, cheeks, tongue, floor of the mouth, palate, and pharynx.

Lip Condition (Color, Texture, Lesions)

Write something...

Cheek Condition (Color, Texture, Lesions)

Write something...

Tongue Condition (Color, Papillae, Ulcerations)

Write something...

Floor of Mouth Condition (Color, Masses, Lesions)

Write something...

Palate Condition (Color, Texture, Lesions)

Write something...

Presence of Ulcerations?

- Yes
- No
- Uncertain

Saliva Characteristics (Quantity, Consistency, Color)

Write something...

Intraoral Examination - Hard Tissues

Evaluate and document the condition of the teeth, gums, and alveolar bone.

Tooth

Enter a number...

Enamel Condition

- Normal
- Hypomineralization
- Demineralization
- Attrition
- Abrasion
- Erosion

Dentin Condition

- Normal
- Sensitivity
- Discoloration

Crown/Restoration Condition (if applicable)

- Intact
- Loose
- Fractured
- Decemented
- Secondary Caries

Notes on Tooth Condition

Write something...

Existing Caries Depth (mm)

Enter a number...

Periodontal Assessment

Record probing depths, recession, bleeding on probing, and mobility.

Probing Depth (Anterior)

Probing Depth (Posterior)

Recession (mm)

Bleeding on Probing (BOP)

Yes

No

Mobility (mm)

- 0
- 1
- 2
- 3

Furcation Involvement

- Class I
- Class II
- Class III
- Class IV
- None

Additional Periodontal Notes

Write something...

Caries Assessment (Tooth Surfaces)

Document the presence and severity of existing and potential caries.

Tooth Surface D1 (Occlusal):

- Sound
- Small Caries
- Moderate Caries
- Extensive Caries
- N/A

Tooth Surface D2 (Mesial-Occlusal):

- Sound
- Small Caries
- Moderate Caries
- Extensive Caries
- N/A

Tooth Surface D3 (Distal-Occlusal):

- Sound
- Small Caries
- Moderate Caries
- Extensive Caries
- N/A

D1 Caries Depth (mm):

Enter a number...

D2 Caries Depth (mm):

Enter a number...

D3 Caries Depth (mm):

Enter a number...

Existing Restoration on Surface D1:

- Amalgam
- Composite
- Gold
- Crown
- None

Restorations & Existing Dental Work

List all existing restorations, crowns, bridges, implants, and other dental work, noting material, size, and condition.

Tooth Number

Enter a number...

Restoration Type

- Amalgam
- Composite
- Crown (Porcelain/Zirconia)
- Inlay/Onlay
- Gold
- Other

Size/Width (mm)

Enter a number...

Condition

- Excellent
- Good
- Fair
- Poor

Notes/Comments

Write something...

Placement Date

Enter date...

Lab/Manufacturer

Occlusion & Bite Analysis

Evaluate and document the patient's bite and occlusal relationships.

Occlusal Class

- Class I
- Class II (Distal Occlusion)
- Class III (Mesial Occlusion)

Overbite (mm)

Enter a number...

Overjet (mm)

Enter a number...

Occlusal Interferences/Premature Contacts

Write something...

TMJ Status

- Normal
- Clicking
- Popping
- Pain/Limited ROM

Deviations/Comments (e.g. Crossbite, Open Bite)

Write something...

Radiographic Assessment

Record type and findings of radiographs taken (e.g., BW, Pano, CBCT).

Radiograph Type(s) Taken

- Bitewing
- Periapical
- Panoramic
- Full Mouth Series
- Cone Beam CT (CBCT)
- Other (Specify in Long Text)

Radiographic Findings (Detailed)

Write something...

Radiograph Date (MM/DD/YYYY)

Enter a number...

Attach Radiograph Image(s)

 Upload File

Radiographic Assessment Quality

- Excellent
- Good
- Fair
- Poor

Treatment Plan Recommendations

Outline proposed treatment modalities, sequencing, and priorities.

Prioritized Treatment Categories

- Restorative
- Preventative
- Periodontal
- Endodontic
- Orthodontic
- Cosmetic

Estimated Treatment Cost

Enter a number...

Proposed Treatment Start Date

Enter date...

Patient Communication Notes (e.g., financial arrangements, treatment explanation)

Write something...

Financial Arrangement Type

- Cash
- Insurance
- Payment Plan

Treatment Sequencing Priority

- High
- Medium
- Low

Additional Notes / Considerations

Write something...