

Dr.A.SH

Evaluation Form

Patient's Name: [Redacted]

File No.: [Redacted]

Patient's Telephone No.: [Redacted]

Age: [Redacted]

Case Classification: [Redacted]

Course Director Signature:

Signature after you complete the case

Treatment Plan

Phase No.	Line of Tx.	Area or tooth no.	Code no.	Procedure	Points No.	Evaluation	Evaluation X Points	Faculty name	Date completed	
II	58.5/6.5 Periodontal		D4000	Periodontics & Tx Plan	1	9	9.0	Medham 21-11-2017	7-11-2017	
			D1110	Prophy	1		9.0		20-11-2017	
			D4351	Gross scaling	2		18		20-11-2017	
			D1330	Oral hygiene Instr.	0.5		4.5		20-11-2017	
			D4998	Perio finished case.	2	9	18	Dr. Xax	19-3-2018	
	Restorative			D2000	Restorative diag & Tx Plan	1	10	10		7-11-2017
		#18	D2330	Resin based comp. 1 surface	0.5	9.0	4.5		4-12-2017	
		#24	D2330	Resin based comp. 2 surface	1	9.0	9.0		30-1-2018	
		#26	D2330	Resin based comp. 1 surface	0.5	9.0	4.5		4-12-2017	
		#27	D2330	Resin based comp. 1 surface	0.5	9.0	4.5		4-12-2017	
		#36	D2331	Resin based comp. 2 surface	1	9.5	9.5		5-12-2017	
		#								
		#45	D2330	Resin based comp. 1 surface	0.5	9.0	4.5		12-12-2017	

