

Dental Implant Evaluation Form

Patient Name

Date of Birth

Phone

Email

Relevant Medical History

Smoking Status

☐ No ☐ Yes

Current Medications

Are you diabetic?

☐ No ☐ Yes

Relevant Dental History

Oral Hygiene

Reason for Dental Implant

Area(s) to be Evaluated

X-rays Taken?

☐ No ☐ Yes

Bite Assessment

Notes / Recommendations