DENTAL EMERGENCY ASSESSMENT FORM

Date: _____ Patient's Name: _____

Time Of Call: _____ Call Handled By: _____

Circle: Current Patient Past Patient New Patient

1. Does The Problem Involve a Tooth? Yes or No
2. If Yes Where Is The Tooth Located? UR LR UL LL Upper Anterior Lower Anterior
3. When Did The Problem Begin?
4. Does The Problem Involve The Tissue Around A Tooth? Yes or No
5. If Yes, Is There Bleeding? Yes or No
6. Is There Pain Yes or No
7. If Yes, How Long Has There Been Pain? _____
8. Is The Pain Consistent? Yes or No Pressure Sensitive: Yes or No
9. Is There Heat Or Cold Sensitivity? _____
10. Is There Swelling? Yes or NO Where? _____
11. When Did The Swelling Begin? _____
12. Is There Drainage? Yes or NO
13. Has There Been Trauma? Yes or No
    Describe_____
14. Does the problem involve a crown or bridge? Yes or No
15. Is Crown/Bridge: Loose Off Porcelain Fractures Other: _____
16. Does The Problem Involve A Denture? Yes or No
17. Denture is: Broken Loose Causing A Sore Spot

Additional Notes: