Restorative Dentists Evaluation Form

Member Name and ID: _____

Restoring Dentist: _____
(Should submit for restoration authorization after osseointegration)

Dental Implant
Placement Dentist:_____
(Should submit for Implants)

Number of Dental Implants: Maxilla _____ Mandible_____

Tooth Numbers Being Replaced (3-14, 19-30 only; must be opposed) _____

Age of the Patient: _____ (Minimum 18 Years Old)

Submitted Documentation:

_____X-rays/ Imaging
_____Periodontal Charting
_____Treatment Plan
_____Signed Member Informed Consent Form
_____Narrative on Exclusion of Other Treatment Options

Does the Patient have/or has had one or more of the following conditions:

Yes	No	
___	___	Diabetes
___	___	Immunosuppression therapy
___	___	Smoker
___	___	Periodontal Disease
___	___	Occlusal trauma
___	___	Parafunctional habits and bruxism
___	___	Endodontic/periapical lesions in adjacent teeth
___	___	Radiotherapy to the jaw bone
___	___	Untreated intraoral pathology or malignancy
___	___	Substance abuse
___	___	Mental Health Condition
___	___	Recent myocardial infarction (MI) or cerebrovascular accident (CVA)
___	___	Reduced manual dexterity or mental capacity
___	___	Does the treatment involve grafts/ sinus lift?
___	___	Does the treatment involve an overdenture?

Signature: _____ Date: _____
Restoring Dentist