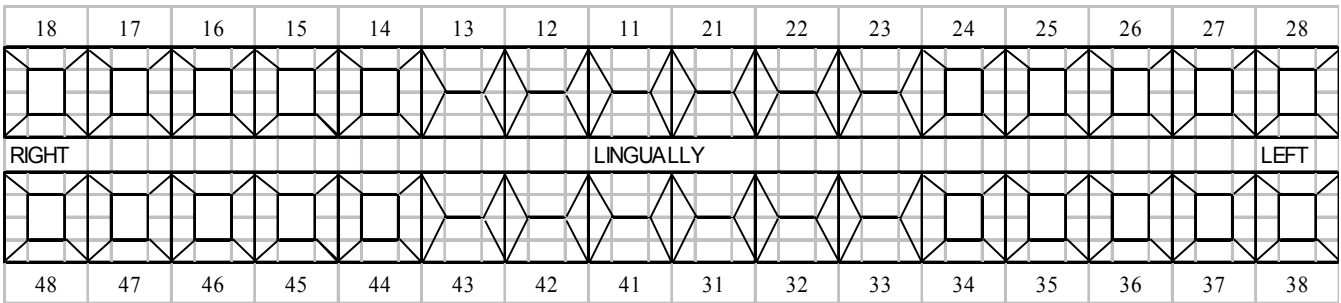


Forensic Dental Examination

Reference No.	
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Patient Name		D.O.B	
Examined At			
On (Date)		Time	
By (Odontologist/s)			
Others Present (Name)			

TOOTH	REMARKS	REMARKS	TOOTH
11			21
12			22
13			23
14			24
15			25
16			26
17			27
18			28



TOOTH	REMARKS	REMARKS	TOOTH
48			38
47			37
46			36
45			35
44			34
43			33
42			32
41			31

Overbite <input style="width: 80%;" type="text"/>	Angles Classification <input style="width: 80%;" type="text"/>	Midline Shift <input style="width: 80%;" type="text"/>	
Overjet <input style="width: 80%;" type="text"/>	Maximal Opening <input style="width: 80%;" type="text"/>	Mid Shift at Max Op <input style="width: 80%;" type="text"/>	

Comments (E.g. mobility status, unusual dental or oral features, etc)

Impressions Upper <input type="checkbox"/> Lower <input type="checkbox"/>	Material Alginate <input type="checkbox"/> PVS <input type="checkbox"/> Other <input type="checkbox"/>	Records Occlusal Record <input type="checkbox"/> Bite Record <input type="checkbox"/> Photographs <input type="checkbox"/>	
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Odontologist Signature