



## ORAL EXAMINATION REPORT

(All sections must be completed)

Please send all claims and inquiries to: **PT. International Services Pacific Cross**  
Chase Plaza Tower 19th Floor - Jl. Jend. Sudirman Kav. 21 Jakarta 12920, Indonesia  
t. (+62.21) 2598 9878 f. (+62.21) 2598 9879  
www.pacificcross.co.id

### SECTION A – PARTICULARS OF THE EXAMINEE

Name	Date of Birth (MM/DD/YY)	Sex
Examination Date (MM/DD/YY)	Member No.	Policy No.
If group insurance, name of the Policyholder		

### SECTION B – EXAMINING DENTIST’S REPORT

1. Have any dental X-rays been taken during this examination? Yes  No   
If “Yes”, please describe nature of X-rays and reason for taking such:

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2. Please describe general condition of dentures (if any):

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3. Other abnormalities or observations: please specify

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4. Diagrammatic Report on Oral Examination (as per symbols and colours overleaf)

**LABIAL**

**RIGHT      LINGUAL      LEFT**

**LABIAL**

Name of Dentist: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No.: \_\_\_\_\_

E-mail: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Dentist with Stamp*

Date: \_\_\_\_\_

## Examination Reporting Code:

1. Please record findings of your examination (including X-rays) on the report form overleaf with the following symbols and colours:

Tooth previously extracted



Tooth now requiring extraction



Previous filling – in sound condition



Previous filling – now requires attention



Cavity requiring filling



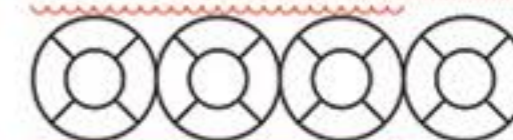
Root abscesses



Gingivitis



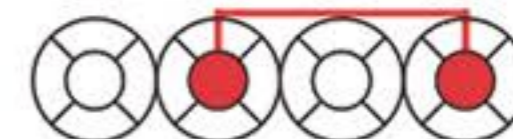
Periodontitis



Bridge (in sound condition)



Bridge requiring attention



Crown – in sound condition



Crown – requiring attention



Wisdom teeth impacted



2. Please mark position of artificial teeth currently on dentures as per illustration:

