CTDHP Treatment Plan Sheet

Patient Name: ____________________

Patient ID: ____________________

Medical Condition(s): ____________________

Social Habit(s): ____________________

Oral Hygiene Status: ____________________

Rank	ADA Code	ADA Procedure Description	Quadrant or Tooth Number	Surface(MODFL)	Date of Completion if Applicable
1	DXXXX	Procedure			
2	DXXXX	Procedure			
3	DXXXX	Procedure			
4	DXXXX	Procedure			
5	DXXXX	Procedure			
6	DXXXX	Procedure			
7	DXXXX	Procedure			
8	DXXXX	Procedure			
9	DXXXX	Procedure			
10	DXXXX	Procedure			
11	DXXXX	Procedure			
12	DXXXX	Procedure			
13	DXXXX	Procedure			
14	DXXXX	Procedure			
15	DXXXX	Procedure			
16	DXXXX	Procedure			
17	DXXXX	Procedure			
18	DXXXX	Procedure			
19	DXXXX	Procedure			
20	DXXXX	Procedure			
21	DXXXX	Procedure			
22	DXXXX	Procedure			
23	DXXXX	Procedure			
24	DXXXX	Procedure			
25	DXXXX	Procedure			

Patient Signature Date: ____________________

Dentist Signature Date: ____________________