

**ORAL PROTOCOL - FORM OP15**

**DENTAL PROSTHESES**

A1. ID LABEL HERE --->

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A2. VISIT #: \_\_\_\_\_

A3. VERSION DATE:

**03/01/95c**

A4. FORM COMPLETED BY:

\_\_\_\_

A5. DATE OF PROCEDURE

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

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Indicate whether a prosthesis exists and whether it is an apparent source of trauma, irritation, or infection.

		<b>YES</b>	<b>NO</b>
B1.	Upper Full	1	2 <b>(B2)</b>
	a. Source of trauma?	1	2
B2.	Upper Partial	1	2 <b>(B3)</b>
	a. Source of trauma?	1	2
B3.	Lower Full	1	2 <b>(B4)</b>
	a. Source of trauma?	1	2
B4.	Lower Partial	1	2 <b>(END)</b>
	a. Source of trauma?	1	2