

ANTERIOR IMPLANT ESTHETIC RISK ASSESSMENT

Dr. _____
 Patient: _____ DOB: _____ Date: _____

Esthetic Risk Factors	Low Risk	Medium Risk	High RISK
Medical Status* Systemic Condition, i.e. Diabetes, Osteoporosis -Bisphosphonates <input type="checkbox"/> -Immune-suppressed <input type="checkbox"/> - Smoker <input type="checkbox"/>	Healthy <input type="checkbox"/> _____ _____	Controlled <input type="checkbox"/> _____ _____	Poorly controlled <input type="checkbox"/> _____ _____
Patient's Esthetic expectations	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Smile Line	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Gingival Biotype (measured 2-3mm subgingival)	<input type="checkbox"/> Thick ≥ 2 mm	<input type="checkbox"/> Medium 1-2mm	<input type="checkbox"/> Thin ≤ 1 mm
Labial Plate (Extraction Site)	<input type="checkbox"/> Intact No Deficiency	<input type="checkbox"/> Dehiscence narrow/shallow	<input type="checkbox"/> Missing Wide Defect
Interproximal Bone (At Adjacent Tooth)	<input type="checkbox"/> ≤ 4.5 mm from contact pt	<input type="checkbox"/> bet. 4.5-5.5mm from contact pt	<input type="checkbox"/> ≥ 6 mm from contact pt
Classification of Site	<input type="checkbox"/> Type 1 Ideal	<input type="checkbox"/> Type 2 Labial Deficiency	<input type="checkbox"/> Type 3 Interproximal Deficiency
Edentulous Span	<input type="checkbox"/> Single Tooth	<input type="checkbox"/> ≥ 3 missing teeth Allowing Pontics	<input type="checkbox"/> 2 adjacent missing teeth
Bone Augmentation As needed	<input type="checkbox"/> Type 1 Intact Socket	<input type="checkbox"/> Horizontal Deficiency	<input type="checkbox"/> Vertical Deficiency
Thickness of facial bone (Extraction Site)	<input type="checkbox"/> ≥ 1.5 mm	<input type="checkbox"/> 1.0 mm	<input type="checkbox"/> ≤ 0.5 mm
Keratinized Gingiva Width	<input type="checkbox"/> ≥ 4 mm Band	<input type="checkbox"/> 2.5-3.5 mm Band	<input type="checkbox"/> ≤ 2.0 mm Band CT Graft Required
Infection at implant site	<input type="checkbox"/> None	<input type="checkbox"/> Chronic	<input type="checkbox"/> Acute - suppuration -
Reason for Tooth Loss	<input type="checkbox"/> Caries, Tooth fracture	<input type="checkbox"/> Endodontic Failure	<input type="checkbox"/> Periodontal Disease, Or Trauma
Nasopalatine Canal	<input type="checkbox"/> No Affect on Implant Orientation	<input type="checkbox"/> Manageable Without grafting	<input type="checkbox"/> Affects Orientation Grafting required
Interdental Space	<input type="checkbox"/> Ideal	<input type="checkbox"/> Restorative on adjacent teeth	<input type="checkbox"/> Orthodontics required

Esthetic Prognosis: ■ Good ■ Guarded ■ Poor
■ Pink Porcelain Likely

Tx Plan Notes: _____

_____ Date: _____