PHILIPPINE DENTAL ASSOCIATION

DENTAL CHART

PATIENT INFORMATION RECORD

Name: _____
Last First Middle

Birthdate (mm/dd/yy): _____/_____/_____Age: _____
Religion: _____ Nationality: _____
Home Address: _____
Occupation: _____
Dental Insurance: _____
Effective Date: _____
For minors:
Parent/ Guardian's Name: _____
Occupation: _____
Whom may we thank for referring you? _____
What is your reason for the dental consultation? _____

Sex: M/F _____
Nickname: _____
Home No.: _____
Office No.: _____
Fax No.: _____
Cel/Mobile No.: _____
E-mail Add: _____

DENTAL HISTORY

Previous Dentist: Dr. _____
Last Dental Visit: _____

MEDICAL HISTORY

Name of Physician: Dr. _____ Specialty, if applicable: _____
Office Address: _____ Office Number: _____

1. Are you in good health?	Yes	No
2. Are you under medical treatment now?	Yes	No
If so, what is the condition being treated? _____		
3. Have you ever had serious illness or surgical operation?	Yes	No
If so, what illness or operation? _____		
4. Have you ever been hospitalized?	Yes	No
If so, when and why? _____		
5. Are you taking any prescription/non-prescription medication?	Yes	No
If so, please specify _____		
6. Do you use tobacco products?	Yes	No
7. Do you use alcohol, cocaine or other dangerous drugs?	Yes	No
8. Are you allergic to any of the following:	Yes	No
( ) Local Anesthetic (ex. Lidocaine) ( ) Penicillin . Antibiotics		
( ) Sulfa drugs ( ) Aspirin ( ) Latex ( ) other _____		
9 Bleeding Time _____	Yes	No
10. For women only: Are you pregnant?	Yes	No
Are you nursing?		
Are you taking birth control pills?		
11. Blood Type _____	Yes	No
12. Blood Pressure _____	Yes	No
13. Do you have or have you had any of the following? Check which apply	Yes	No

( ) High Blood Pressure ( ) Heart Disease ( ) Cancer / Tumor
( ) Low Blood Pressure ( ) Heart Murmur ( ) Anemia
( ) Epilepsy / Convulsion ( ) Hepatitis / Liver Disease ( ) Angina
( ) AIDS or HIV Infection ( ) Rheumatic Fever ( ) Asthma
( ) Sexually Transmitted Disease ( ) Hay Fever / Allergies ( ) Emphysema
( ) Stomach Trouble(s) / Ulcers ( ) Respiratory Problem ( ) Bleeding Problems
( ) Fainting Seizure ( ) Hepatitis / Jaundice ( ) Blood Disease
( ) Rapid Weight Loss ( ) Tuberculosis ( ) Head Injuries
( ) Radiation Therapy ( ) Swollen ankles ( ) Arthritis / Rheumatism
( ) Joint Replacement / Implant ( ) Kidney Disease ( ) Other
( ) Heart Surgery ( ) Diabetes
( ) Heart Attack ( ) Chest pain
( ) Thyroid Problem ( ) Stroke

_____
Signature

INFORMED CONSENT

TREATMENT TO BE DONE: I understand and consent to have any treatment done by the dentist after the procedure, the risk & benefits and cost have been fully explained. These treatments include, but are not limited to, x-rays, cleanings, periodontal treatments, fillings, crowns, bridges, all types of extraction, root canals and/or dentures, local anesthetics and surgical cases. (Initial:_____)

DRUGS & MEDICATIONS: I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock. (Initial:_____)

CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change/add procedures because of conditions found while working on the teeth that was not discovered during examination. For example, root canal therapy is following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary with my responsibility to pay all the costs agreed. (Initial:_____)

RADIOGRAPH: I understand that x-ray shot or a radiograph maybe necessary as part of diagnostic aid to come up with tentative diagnosis of my dental problem and to make a good treatment plan, but, this will not give me a 100% assurance for the accuracy of the treatment since all dental treatments are subject to unpredictable complications that later on may lead to sudden change of treatment plan and subject to new changes. (Initial:_____)

REMOVAL OF TEETH: I understand that alternatives to tooth removal (root canal therapy, crowns & periodontal surgery, etc.) and I agree completely that these alternatives, including their risk & benefits prior to authorizing the dentist to remove teeth and any others necessary for reasons above. I understand that removing teeth does not always remove all the infections, if present and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, fractured jaw, loss of feeling teeth, lips, tongue & surrounding tissue that can last for an indefinite period of time. I understand that I may need further treatment of specialist if complications arise during or following treatment. (Initial:_____)

CROWNS (CAPS) & BRIDGES: Preparing a tooth may irritable the nerve tissue in the center of the tooth, leaving your tooth feeling sensitive to heat, cold & pressure. Treating such irritation may involve using special toothpastes or mouth rinses or root canal therapy. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. It is my responsibility to return for permanent cementation within 20 days from tooth preparation, as excessive days delay may allow for tooth movement, which may necessitate a remake of the crown, bridge/cap. I understand there will be additional charges for remakes due to my delaying of permanent cementation and I realize that final opportunity to make changes in my new crown, bridges or cap (including shape, fit, size and color) will be before permanent cementation. (Initial:_____)

ENDODONTICS (ROOT CANAL): I understand there is no guarantee that root canal treatment will save a tooth and that complications can occur from the treatment and that occasionally root canal filling materials may extend through that tooth which does not necessarily effect the success of the treatment. I understand that endodontic files and drills are very fine instruments and stresses vented in their manufacture & clarifications present in teeth can cause them to break during use. I understand that referral to the endodontist for additional treatments may be necessary following any root canal treatment and I agree that I am responsible for any additional cost for treatment performed by the endodontist. I understand that a tooth may require in spite of all efforts to save it. (Initial:_____)

PERIODONTAL DISEASE: I understand that periodontal disease is a serious condition causing gums & bone inflammation and/or loss and that can lead to the loss of my teeth. I understand that alternative treatment plans to correct periodontal disease, including gum surgery tooth extractions with or without replacement. I understand that undertaking any dental procedures may have future adverse effect on my periodontal conditions. (Initial:_____)

FILLINGS: I understand that care must be exercised in chewing on fillings, especially during the first 24 hours to avoid breakage. I understand that a more extensive filling or a crown may be required, as additional decay or fracture may become evident after initial excavation. I understand that significant sensitivity is a common, but usually temporary, after effect of a newly placed filling. I further understand that filling a tooth may irritate the nerve tissue creating sensitivity and treating such sensitivity could require root canal therapy or extractions. (Initial:_____)

DENTURES: I understand that wearing of dentures can be difficult. Sore spots, altered speech & difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges. A permanent reline will be needed later, which is not included fee. I understand that all adjustments or alterations of any kind after this initial period is subject to charges. (Initial:_____)

I understand that dentistry is not an exact science and that no dentists can properly guarantee results.

I hereby authorize any of the dentists to proceed with and perform the dental restorations & treatments as explained to me. I understand that this is subject to modification depending on undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees, I agree to pay my attorney's fees, collection fee, or court costs that may be incurred to satisfy any obligation to this office. All treatment were properly explained to me

and any untoward circumstances that may arise during the procedure, the attending dentist will not be held liable since it is my free will with full trust and confidence to undergo dental treatment under their care.

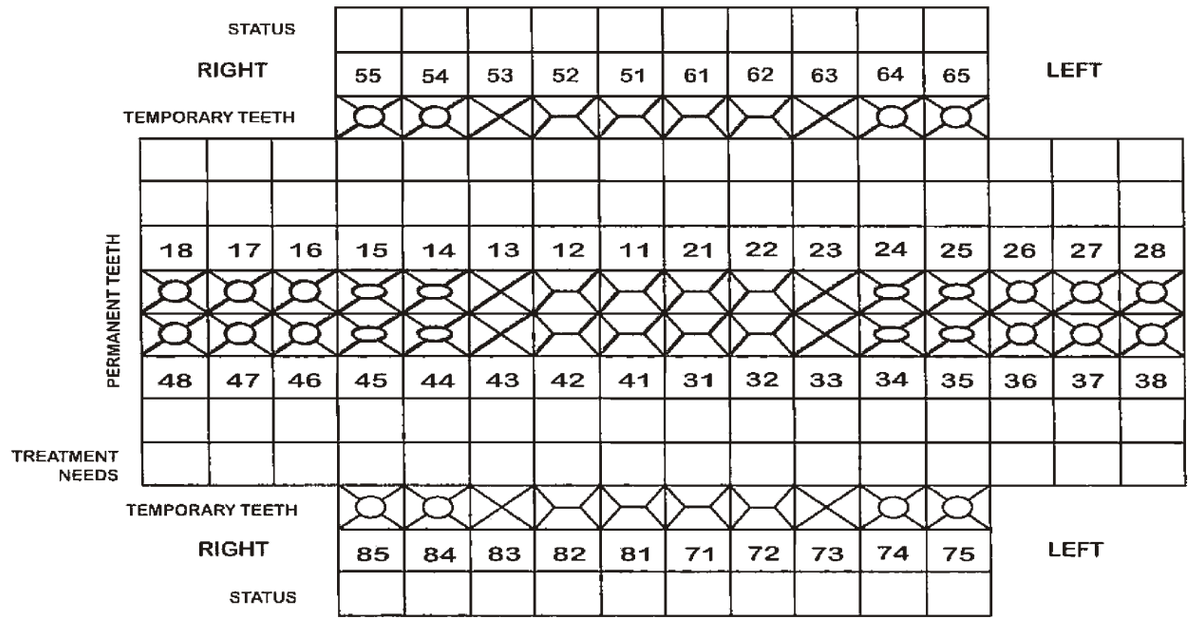
_____	_____	_____
Patient/Parent/Guardian Signature	Dentist/Signature	Date

DENTAL RECORD CHART

INTRAORAL EXAMINATION

Name _____ Age _____ Gender: _____

DENTITION STATUS AND TREATMENT NEEDS



Legend: Condition

- **D -** Decayed (Caries Indicated for Filling)
- **M -** Missing
- **F -** Filled
- **I -** Caries Indicated for Extraction
- **RF -** Root Fragment
- **MO -** Missing due to Other Causes
- **Im -** Impacted Tooth

Restorations & Prosthetics

- **J -** Jacket Crown
- **A -** Amalgam Filling
- **AB -** Abutment
- **P -** Pontic
- **In -** Inlay
- **Fx -** Fixed Cure Composite
- **S -** Sealants
- **Rm -** Removable Denture

- **X -** Extraction due to Caries
- **XO -** Extraction due to Other Caries

√ Others

- **-** Present Teeth
- **Cm-**Congenitally Missing
- Sp-Supernumerary

Periodontal Screening

_____ Gingivitis
_____ Early Periodontitis
_____ Moderate Periodontitis
_____ Advanced Periodontitis

Occlusion

_____ Class (Molar)
_____ Overjet
_____ Overbite
_____ Midline Deviation
_____ Crossbite

Appliances:

_____ Orthodontic
_____ Stayplate
_____ Others _____
_____
_____

TMD:

_____ Clenching
_____ Clicking
_____ Trismus
_____ Muscle Spasm

Name: ______________________________________

TREATMENT RECORD

Date	Tooth No./s	Procedure	Dentist/s	Amount Charged	Amount Paid	Balance