Republic of the Philippines
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ISO CERTIFIED

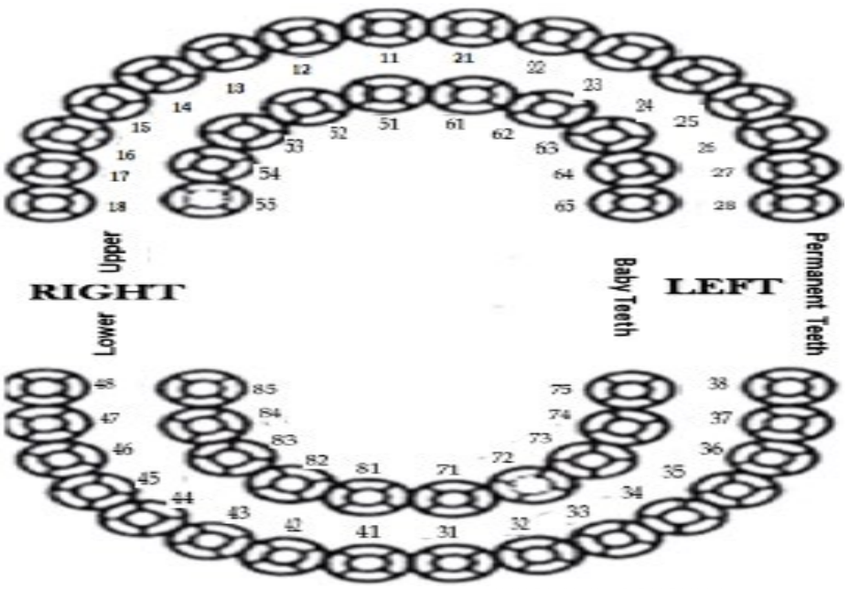
DENTAL RECORD

Type of Patient: ___STUDENT NO._____
___EMPLOYEE; Dept._____
___DEPENDENT ___OTHERS

NAME: _____COURSE, YEAR & SECTION:_____
AGE: _____SEX:_____ BIRTHDAY: _____CIVILSTATUS: _____RELIGION: _____
ADDRESS: _____CONTACT NO._____
For Child Patient
NAME OF GUARDIAN: _____ Relationship: _____
Address _____Contact No: _____

MEDICAL HISTORY: Put x in the appropriate blank provided.
___Allergy ___Rheumatic Heart Fever ___Familial ___Kidney Disease ___Diabetes
___Cardiac Disease ___Common Childhood Diseases ___Asthma ___Blood Dyscrasias ___Others: pls. specify_____
DENTAL HISTORY: Put x in the appropriate blank provided

DENTAL CHART



Legend:
– Caries
- Permanent filling
-Temp. Filling
RF- Root Fragment
P – Pontic
X – for extraction
UE – Unerupted
JC – Jacket Crown
M – missing

Summary of Dental Status

No. of Dental Caries: _____
No. of Missing Teeth: _____
No. of Filled Teeth: _____
Total (DMFT): _____

INFORMED CONSENT

I understand and consent to have any treatment done by the dentist after the procedure, the risk and benefits and cost have been fully explained.

REMOVAL OF TEETH: I understand that alternatives to tooth removal (root canal therapy, crown & periodontal surgery, & etc.) and I completely understand these alternatives, including their risks and benefits prior to authorizing the dentist to remove teeth and any other structures necessary for reasons above. I understand that removing teeth does not always remove all infections, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, such as pain, swelling, and spread of infection, dry socket, and fractured jaw, loss of feeling on the teeth, lips, tongue, and surrounding tissue that can last for an indefinite period of time. I understand that I may need further treatment under a specialist if complications arise during or following treatment.
(Initial……..……); (Initial……..……); (Initial……..……..……); (Initial……);
.
FILLINGS: I understand that care must be exercised in chewing on fillings, especially during the 1st 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 as common, but usually temporary, after the 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 extraction.
(Initial……..) ;(Initial……..……); (Initial……); (Initial……..……);

I understand that dentistry is not an exact science and that no dentist can properly guarantee accurate result all the time.
I hereby authorize the attending dentist to proceed with & perform the dental restoration & treatment as explained to me. I understand that these are subject to modification depending on undiagnosable circumstances that may arise during the course of treatment. All treatment were properly explained to me and any untoward circumstances that may arise during and after the procedure, the attending dentist will not be held liable since it's my free will, with full trust and confidence in him/her, to undergo dental treatment under his/her care.

DATE	TOOTH NUMBER	DIAGNOSIS	TREATMENT AND MANAGEMENT