**DEPARTMENT OF CONSERVATIVE DENTISTRY AND ENDODONTICS**

**SATHYABAMA DENTAL COLLEGE AND HOSPITAL**

**CASE RECORD**

Pt. Name : Medical Alert

Age/Sex :

Address : Dr. Name :

Date :

O.P.No. :

Occupation :

Phone No. :

DENTAL HISTORY

Chief complaint :

History of presenting illness :

PAST DENTAL HISTORY :

PAST MEDICAL HISTORY:

Hypertensive / Diabetes / Cardiac Problems / others

If Yes, details of the medication :

Allergies if any :

**CLINICAL EXAMINATION**

EXTRA ORAL EXAMINATION:

INTRA ORAL EXAMINATION:

Inspection :

Palpation :

Percussion :

PERIODONTAL STATUS

Pockets: Furcation involvement : Mobility:

PROVISIONAL DIAGNOSIS :

DIFFERENTIAL DIAGNOSIS:

DIAGNOSTIC TESTS

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Test | Control Tooth | Test tooth | Response | Interpretation |
|  |  |  |  |  |

Radiographic Interpretation :

Other Investigations :

DIAGNOSIS :

TREATMENT ADVISED :

PATIENT MOTIVATION : High / Moderate / Poor

TREATMENT NOTES :

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Treatment Done | Remarks | Signature |
|  |  |  |  |

Payment Amount : Receipt No.

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Treatment Done | Remarks | Signature |
|  |  |  |  |

**ENDODONTIC CASE RECORD**

**Pt. Name : Date:**

**Tooth no. :**

Canal WL IAF MAF MC

**Access Cavity Preparation and**

**Pulp extirpation**:

**Bio- Mechanical Preparation**

Length determined :

Instrument used :

Technique used :

Irrigants used :

WL – Working Length

IAF – Initial Apical File

MAF – Maximum Apical

MC – Master Cone

**Obturation**

Complete / sectional :

Technique : Cold Lateral / Warm Vertical / Thermo plasticized

Sealer Used :

**Post Operative Radiograph**

Apical fit :

Lateral condensation :

**Entrance filling** :

Post endodontic restoration :

**Post Operative Follow Up** :

**Signature**

**RADIOGRAPHIC INTERPRETATION**

**EXISTING RESTORATIONS AND STATUS**

**RADIOGRAPHIC PULP EXPOSURE**

**LAMINA DURA**

**PERIAPICAL RADIOLUCENCY**

1. No. of teeth involved
2. Size & shape
3. Nature of radiolucency

**PERIODONTAL STATUS**

1. Periodontal space widening
2. Interdental bone loss

**NATURE OF ROOT CANAL IN INVOLVED TOOTH**

1. No of roots
2. Anatomical variations
3. Others ,if any

**PREVIOUS ENDODONTIC TREATMENT**

1. Status of root canal filling
2. Status of retrograde filling

**FRACTURE OF TEETH**

1. Crown
2. Root

**ANY OTHER ABNORMALITIES**