SEVENTH-DAY ADVENTIST CHURCH
Lake Union Conference

OFFICE USE ONLY

DATE: ____________________ COUNTRY: USA
YYYY-MM-DD

CLINIC: ____________________

Patient Dental Record

Personal

LAST NAME	FIRST NAME	MI	☐ Male ☐ Female

ADDRESS	CITY	STATE	ZIP

EMAIL	PHONE	BIRTH DATE	AGE

Assessment

TRIAGE MUST CHECK THE FOLLOWING: BP TEMP PULSE RESP

REGULAR DENTAL CARE? ☐ Yes ☐ No

VACCINATIONS
- ☐ Tetanus ☐ Measles ☐ Polio
- ☐ Diphth ☐ Rubella ☐ Mumps
- ☐ Other____________

DRUG ALLERGIES
- ☐ None ☐ Emycin ☐ Cephalosporin
- ☐ PCN ☐ Flagyl ☐ Fluoroquinolones
- ☐ Sulfa ☐ TCN/DCN ☐ Spectinomycin
- ☐ Other____________

LAST DENTAL VISIT (WHEN AND WHY)

MEDICAL HISTORY
- ☐ Chicken Pox
- ☐ Malaria
- ☐ Measles
- ☐ Mumps
- ☐ Parasites
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Hearing Loss
- ☐ Radiation TX
- ☐ Seizures
- ☐ Tobacco Use
- ☐ Vision Loss
- ☐ Wears Glasses/Contacts
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ Heart Valve
- ☐ Hepatitis (Circle: A B C D E)
- ☐ High or Low BP
- ☐ HIV+
- ☐ Joint Replacement
- ☐ Leaky Heart Valve
- ☐ Tuberculosis

CURRENT MEDICATIONS

FEMALES ONLY LMP PREGNANT? ☐ Yes ☐ No ☐ Possibly

Dental

TRIAGE

____
Triage Signature

____
Triage Name (please print)

X-RAY LIST (Record numbers)

PA-X # ________ Bite Wing # 2 ________

Panorex ________ Bite Wing # 4 ________

HYGIENE
- ☐ Prophylaxis ☐ Root Planing
- ☐ Scaling ☐ Fluoride
- ☐ Gross Debridement

____________________ ________
Signature Initials

☐ Dentist ☐ Hygienist ☐ Student

EXTRACTIONS

☐ Simple
Total # ________
List Teeth ____________

☐ Surgical
Total # ________
List Teeth ____________

☐ Other Oral Surgery____________________

FILLINGS

Amalgams
- ☐ Tooth # ______ ☐ Tooth # ______
- ☐ Tooth # ______ ☐ Tooth # ______

Composites
- ☐ Tooth # ______ ☐ Tooth # ______
- ☐ Tooth # ______ ☐ Tooth # ______

SERVICES (Record numbers)
- ☐ Alveoplasty ________
- ☐ Buccal ________
- ☐ Core Build Up ________
- ☐ Denture Repair ________
- ☐ Direct/Indirect Pulp Cap ________
- ☐ Other ____________________
- ☐ IRM ________
- ☐ Pulpotomy ________
- ☐ Root Canal ________
- ☐ Sealant ________
- ☐ Temp Crown ________

NOTES (Please write legibly)

DENTIST'S SIGNATURE	PRINT NAME