2018 SEATTLE/KING COUNTY CLINIC
PATIENT DENTAL RECORD

PATIENT LABEL REQUIRED PLACE PATIENT LABEL IN THIS BOX

PATIENT INTAKE Station: Intake Provider: HT: WT:

BP (<180/100 - Dental): Pulse: Temp: Gluc/if Diabetic (<200 Dental Extract):

POS (+) SCREEN TB: ☐ N ☐ Y Measles: ☐ N ☐ Y Scabies: ☐ N ☐ Y Other: ☐ N ☐ Y

HEALTH HISTORY

☐ **NONE**
☐ **Recent hospitalization**

Cardio / Circulatory
☐ Angina
☐ Arrhythmia
☐ Bleeding disorder
☐ Heart attack Yr:____
☐ Heart disease
☐ Hyper / Hypotension

Dental
☐ Adverse dental RXN
☐ Bisphosphonate / ever used
☐ Dental anxiety
☐ Oral cancer

Digestive / Excretory
☐ Asplenia
☐ Liver disease

Endocrine
☐ Diabetes

Muscular / Skeletal
☐ Joint replacement

Nervous System
☐ Seizures
☐ Stroke

Reproductive
☐ Breastfeeding (currently)
☐ Pregnant

Respiratory
☐ Asthma

Other
☐ Radiation therapy: Head / Neck

Psychosocial
☐ Alcohol use
☐ Anxiety
☐ Behavioral disorders/concerns
☐ Emotional concerns
☐ E-Cigarette/Vapor use
☐ Marijuana use
☐ Tobacco use
☐ Intravenous drug use
☐ Opioid use
☐ Other substance/drug use
☐ Overdosed on drugs

Infectious Disease
☐ Active infectious disease
Type: _____
SX: ☐ Respiratory illness
☐ Gastro illness
☐ Fever last 24 hours
☐ Hepatitis A B C
☐ HIV
☐ MRSA
☐ STI: _____

Vaccinations
☐ Hep A / Hep B

Vision
☐ Cataracts
☐ Conjunctivitis: current / recurrent
☐ Glaucoma
☐ Vision loss

Recommendations:
☐ FOCUS (Behavioral Health App)
☐ Opioid Risk Assessment
☐ NTHK Issued

ALLERGIES
☐ None
☐ Aspirin
☐ Other:
☐ Clindamycin ☐ Codeine/Narcotics ☐ Erythromycin
☐ Latex ☐ Penicillin/Antibiotics ☐ Sulfa

CURRENT RX
☐ None
☐ Antibiotics
☐ Other:
☐ Antidepressants ☐ Antihistamine ☐ Bisphosphonate
☐ Blood thinners ☐ Hormones ☐ Hydroxychloroquine
☐ Insulin ☐ Metformin ☐ Methotrexate
☐ Statins ☐ Steroids ☐ Tamoxifen

DENTAL TRIAGE Dentist Name (Print):

Primary Complaint	Proposed Plan (Triage Dentist)	Confirmed Plan (X-Ray Dentist)

NEEDS SURVEY:
☐ Pathology ☐ Complicated Extractions ☐ Perio (Beyond Prophy) ☐ Endo ☐ Removable Pros ☐ Fixed Pros ☐ 3+ Surface restorations

ORAL CANCER SCREEN: ☐ Normal ☐ Abnormal ☐ Referral Needed

X-RAY Dentist Name (Print):

Ordered	Type	Area
	0330 Panorex	
	0270,2,3,4 BWX	
	0220 1st PA	
	0230 Add'tl PA	

ANESTHETIC

	Amount	Area
Carbocaine/Mepivacaine 3% w/o Epi		
Lidocaine/ Prilocaine 2% w/Epi 1:100k		
Marcaine 0.5% w/Epi 1:200k		
Septocaine/ Articaine 4% w/Epi 1:100k		

TREATMENT DELIVERED

0150	Exam	1

Restorative: — Tooth Numbers/Surfaces

2140	Amalgam/1 Surf	
2150	Amalgam/2 Surf	
2160	Amalgam/3 Surf	
2161	Amalgam/4 Surf	
2330	Ant Comp/1 Surf	
2331	Ant Comp/2 Surf	
2332	Ant Comp/3 Surf	
2335	Ant Comp/4 Surf	
2391	Post Comp/1 Surf	
2392	Post Comp/2 Surf	
2393	Post Comp/3 Surf	
2394	Post Comp/4 Surf	

Surgery: — Tooth Numbers

7111	Coronal Remnants	
7140	Extractions/Roots	
7210	Surgical Removal	
7220	Ext Imp Soft Tissue	
7230	Ext Imp Part Bony	
7240	Ext Imp Comp Bony	
7250	Extraction Roots-Sur	
7310	Alveoloplasty w/Ext	

Endo:

2950	Core Buildup/Crown	
2954	Prefab Post/Core	
3110	Pulp Cap – Direct	
3120	Pulp Cap – Indirect	
3220	Pulpotomy	
3310	Root Canal – Ant	
3320	Root Canal – Bi	
3330	Root Canal – Molar	

CEREC: — Tooth Numbers

2740	Porcelain Crown	

Hygiene: — Number of Services

1110	Adult Prophy	
1120	Child Prophy	
1206	Fluoride App	
1330	Oral Hyg Inst	1
1351	Sealant	
4342	PerioScale/1 Quad	
4355	Debridement	

Pros: — Number of Services

5650	Add tooth partial	
5821	Flipper	
	Denture Repair	

SDF: — Tooth Numbers

1354	Silver Diamine Fluoride	

ADDITIONAL TREATMENT NOTES

PROVIDER NAME (Print): **CHAIR NUMBER:** **DATE:**

ADDITIONAL TREATMENT NOTES

PROVIDER NAME (Print): **CHAIR NUMBER:** **DATE:**

CONSENT FOR SILVER DIAMINE FLUORIDE

Silver diamine fluoride (SDF) is a minimally invasive option to treat tooth decay designed to slow down and at times stop cavities from growing in teeth until they can be fixed at a later date. I have been advised that SDF can permanently stain the treated area dark brown or black. I have consented for this procedure, knowing that the discoloration to the treated tooth/teeth may be permanent.

PATIENT/GUARDIAN SIGNATURE: **DATE:**

PHARMACY

PRE-MEDICATION

Pre-Packaged Prescriptions	Dentist Name (Printed)	Pharmacist Intials
☐ Amoxicillin 500mg (4)		
☐ Clindamycin HCL 300mg (2)		

PHARMACIST NAME (Print) : **DATE:**

RX DISPENSED ONSITE

Pre-Packaged Prescriptions	Dentist Name (Printed)	Pharmacist Intials
☐ Acetaminophen 500mg (4)		
☐ Acetaminophen 325mg (15)		
☐ Acetaminophen 500mg (15)		
☐ Amoxicillin 500mg (30)		
☐ Clindamycin HCL 300mg (40)		
☐ Ibuprofen 200mg (4)		
☐ Ibuprofen 600mg (15)		

Patient consented to counseling: ☐ YES ☐ NO **Patient Signature:**

PHARMACIST NAME (Print) : **DATE:**

PRESCRIPTION WRITTEN TO BE FILLED OFF SITE

Transcribe RX Written, Quantity & Dosage	Dentist Name (Printed)

Prescriptions written to be filled off site were reviewed and confirmed by Seattle/King County Clinic Pharmacist.

PHARMACIST NAME (Print) : **DATE:**

DIRECTOR AUTHORIZATION

☐ RFC: _____

☐ EMG REF: _____

HYGIENE KIT

☐ Hygiene Kit: _____