2025 SEATTLE/KING COUNTY CLINIC
PATIENT DENTAL RECORD

PATIENT LABEL REQUIRED

PLACE PATIENT LABEL IN THIS BOX

DENTAL TRIAGE Dentist Name (Print):

Primary Complaint	Triage Notes

ORAL CANCER SCREEN: □ Normal □ Abnormal □ Referral Needed

X-RAY □ None

# Ordered	Type	Area / Tooth #s
	0330 Panorex	
	0270,2,3,4 BWX	R molar R premolar L molar L premolar
	0220 1st PA	
	0230 Add'l PA	

TREATMENT PLAN ***For Dental Leadership Use Only***

Seq: R: _____ C: _____ S: _____ E: _____ H: _____ P: _____ OM: _____

LEADERSHIP AUTHORIZATION (Print Name):

ANESTHETIC

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

TREATMENT DELIVERED

0140 Limited 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 _____

CEREC: **Tooth Numbers**

2740 Porcelain Crown _____

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 Ext - Roots Surg _____
7310 Alveoloplasty w/Ext _____

Endo: **Tooth Numbers**

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 _____

Hygiene: **Number of Services**

1110 Adult Prophy _____
1120 Child Prophy _____
1206 Fluoride App _____
1330 Oral Hyg Inst 1
1351 Sealant _____
4341 PerioScale/1 Quad _____
4355 Debridement _____

Pros: **Number of Services**

5650 Add Tooth Partial _____
Denture Repair _____
5821 Temp Partial (Flipper) _____
□ Impression Completed Date _____
□ Delivery Completed Date _____

Oral Medicine: **Number of Services**

Biopsy _____
Mouth Guard _____
Trigger Point Injection _____

Other: **Tooth Numbers**

Silver Diamine Fluoride _____

ADDITIONAL TREATMENT NOTES

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

See page 2 for added treatment notes, pre-medication, Rx

#Dental

ADDITIONAL TREATMENT NOTES

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

ADDITIONAL TREATMENT NOTES

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

PHARMACY

PRE-MEDICATION

Pre-Packaged Prescriptions	Dentist Name (Printed)	Pharmacist Initials
□ Amoxicillin 500mg (4)		
□ Azithromycin 250mg (2) *Use instead of Clindamycin*		

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

RX DISPENSED ONSITE

Pre-Packaged Prescriptions	Dentist Name (Printed)	Pharmacist Initials
□ Acetaminophen 325mg (15)		
□ Acetaminophen 500mg (4)		
□ Acetaminophen 500mg (15)		
□ Amoxicillin 500mg (30)		
□ Azithromycin 250mg (6) *Use instead of Clindamycin*		
□ Ibuprofen 200mg (4)		
□ Ibuprofen 600mg (15)		

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

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

PRESCRIPTION TO BE FILLED OFFSITE

Transcribe Written Rx, Quantity & Dosage

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

DIRECTOR AUTHORIZATION

□ FIN SVC: _____ SERVICE: _____ DATE: _____

□ EMG REF: _____ □ BIOPSY _____

HYGIENE KIT

□ Hygiene Kit: _____

Date: _____