

2026 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: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Referral Needed					
X-RAY <input type="checkbox"/> 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		<i>For Dental Leadership Use Only</i>			
Seq: R: _____ C: _____ S: _____ E: _____ H: _____ P: _____ OM: _____					
LEADERSHIP AUTHORIZATION (Print):					

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/ Articaïne 4% w/Epi 1:100k	_____

TREATMENT DELIVERED		Surgery:	Tooth Numbers	Hygiene:	Number of Services		
0140	Limited Exam	1	7111	Coronal Remnants	1110	Adult Prophyl	_____
Restorative:		7140		Extractions/Roots	1120	Child Prophyl	_____
2140	Amalgam/1 Surf	_____	7210	Surgical Removal	1206	Fluoride App	_____
2150	Amalgam/2 Surf	_____	7220	Ext Imp Soft Tissue	1330	Oral Hyg Inst	1
2160	Amalgam/3 Surf	_____	7230	Ext Imp Part Bony	1351	Sealant	_____
2161	Amalgam/4+ Surf	_____	7240	Ext Imp Comp Bony	4346	Full Mouth Scaling	_____
2330	Ant Comp/1 Surf	_____	7250	Ext - Roots Sur	4355	Debridement	_____
2331	Ant Comp/2 Surf	_____	7310	Alveoplasty w/Ext	Pros:		Number of Services
2332	Ant Comp/3 Surf	_____	Endo:		5650	Add Tooth Partial	_____
2335	Ant Comp/4+ Surf	_____	2950	Core Buildup/Crown	5821	Denture Repair	_____
2391	Post Comp/1 Surf	_____	2954	Prefab Post/Core	<input type="checkbox"/> Impression Completed Date: _____ <input type="checkbox"/> Delivery Completed Date: _____		
2392	Post Comp/2 Surf	_____	3110	Pulp Cap – Direct	Oral Medicine:		Number of Services
2393	Post Comp/3 Surf	_____	3120	Pulp Cap – Indirect		Biopsy	_____
2394	Post Comp/4+ Surf	_____	3220	Pulpotomy		Eval/Consult	_____
CEREC:		3310		Root Canal – Ant		Mouth Guard	_____
2740	Porcelain Crown	_____	3320	Root Canal – Bi		Trigger Point Injection	_____
			3330	Root Canal – Molar	Other:		Tooth Numbers
						Silver Diamine Fluoride	_____

ADDITIONAL TREATMENT NOTES

PROVIDER NAME (Print): _____	CHAIR NUMBER: _____	DATE: _____
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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 WRITTEN TO BE FILLED OFFSITE

Transcribe Written Rx, Quantity & Dosage

PROVIDER NAME (Print):

DATE:

DIRECTOR AUTHORIZATION**HYGIENE KIT** FIN SVC: _____ SERVICE: _____ DATE: _____ Hygiene Kit: _____

Date: _____

 EMG REF: _____ BIOPSY: _____