

PHC Dental Registration & Exam Form

For Staff use

Vital Signs

Blood Pressure: _____/_____
Pulse: _____

- Premed ABX
 Blood Thinner

PHC Dental # _____

MA # _____

Last Name _____

First Name _____

Date of Birth _____

Name of Shelter or Drop in Center _____
or address: _____

General Health History

Do you have or have you had? (check box if yes)

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Abnormal heart condition | <input type="checkbox"/> Abnormal blood pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Artificial Joint |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mitral Valve Prolapse | Date of Surgery _____ |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Women Are you Pregnant | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> HIV positive/AIDS |
| <input type="checkbox"/> Radation Treatment | <input type="checkbox"/> Excessive or prolonged Bleeding | |

Have you had any other serious illness, hospitalization or accident? Yes No

If yes please explain _____

List any medications/drugs you are presently taking (include over-the counter meds)?

Are you allergic/sensitive to: Pencillin Codeine Local anesthetic Latex None

Other allergies: _____

Dental Information

Why are you seeking dental care? _____

- | | | | |
|---|--------------------------------------|--|---|
| Tooth Concern | Location | Do you wear dentures or partials? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Problems chewing | <input type="checkbox"/> Upper Right | If yes, do you have any concerns/problems with your dentures? _____ | |
| <input type="checkbox"/> Broken Tooth | <input type="checkbox"/> Lower Right | | |
| <input type="checkbox"/> Pain Level 1-5 _____ | <input type="checkbox"/> Upper Left | I would like to be evaluated for dentures | |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Lower Left | | <input type="checkbox"/> Upper Partial <input type="checkbox"/> Lower Partial |
| <input type="checkbox"/> Other _____ | | | <input type="checkbox"/> Upper Full <input type="checkbox"/> Lower Full |

Consent: By signing this form I authorize the dentist and staff to provide oral and dental examinations, x-rays, treatment and payment activities. I consent to the use and disclosure of my protected health information to carry out treatment, healthcare operations and photograph.

Patient Signature: _____

Date: _____

Teeth Clinical Assess

X-ray taken

Treatment Plan

Progress Notes

Provider initials: _____

Circle teeth to be radiographed

R	1	_____	_____	_____	_____
	2	_____	_____	_____	_____
	3	_____	_____	_____	_____
	4	_____	_____	_____	_____
	5	_____	_____	_____	_____
	6	_____	_____	_____	_____
	7	_____	_____	_____	_____
	8	_____	_____	_____	_____
L	9	_____	_____	_____	_____
	10	_____	_____	_____	_____
	11	_____	_____	_____	_____
	12	_____	_____	_____	_____
	13	_____	_____	_____	_____
	14	_____	_____	_____	_____
	15	_____	_____	_____	_____
	16	_____	_____	_____	_____
L	17	_____	_____	_____	_____
	18	_____	_____	_____	_____
	19	_____	_____	_____	_____
	20	_____	_____	_____	_____
	21	_____	_____	_____	_____
	22	_____	_____	_____	_____
	23	_____	_____	_____	_____
	24	_____	_____	_____	_____
R	25	_____	_____	_____	_____
	26	_____	_____	_____	_____
	27	_____	_____	_____	_____
	28	_____	_____	_____	_____
	29	_____	_____	_____	_____
	30	_____	_____	_____	_____
	31	_____	_____	_____	_____
	32	_____	_____	_____	_____

Key:

- EC = Extensive Caries
- RT = Root tip
- EXN = Extraction
- EXS = Surgical Extraction
- PA = Periapical Abscess

Assessment/Triage/Referral

STE/OCE

- WNL Abnormal
- No obvious Tx.
- Early Tx.
- Urgent TX

Proceed to:

- X-Ray & Diagnosis
- Denture Voucher
- Future Appointment w/ Dentist
- Dental Comm. Referral List