

PATIENT TREATMENT RECORD — FOR DENTIST'S USE ONLY

Name _____ Age _____ DOB ____ / ____ / ____ Date ____ / ____ / ____

Address _____ City/ST _____ Zip _____

Email: _____ Phone: _____

Diagnostic Criteria: Perio _____ Crowding _____ Pt. Election _____

Prev. Pain/Swelling _____ N/R Caries _____ Cyst _____ Other _____

M.H.R. Pertinent Findings: _____

_____ Allergies: _____

Consent Signed N.P.O. x _____ hrs. Pt. Voided Smoker Pregnancy ASA _____

Dentist's Office: _____ Fee: _____

Procedure Planned: _____ S/F: _____

Pre-Operative X-ray: Pano PA Other _____ Date ____ / ____ / ____ I/F: _____

Pre-Op Meds/Drugs: _____ O/F: _____

Post-Op Ride: _____ Post-Op Ride's #: _____

Pre-Op Vital Signs: ECG _____ PSO2 _____ BP _____ RR _____

Sutures: Silk; Gut; Vicryl; _____ Assts: _____ Asst. Fee: _____

Rx:

Norco 7.5/325mg _____
Cleocin 150mg x _____
Penn Vk 500mg x _____
Zofran ODT 8mg x _____
Peridex (1 pint) x _____
Decadron 4mg x _____
Other _____

Start Time :	→ 0	0	1	1	2	2	3	3	4	4	5	5	6	Admin/Wasted
Triazolam/cc	.25 mg/cc													/
														/
														/
Oxygen (L/Min)														
N20 (L/Min)														
2% Lidocaine Carps.	1:100k													
0.5% Marcaine Carps.	1:200k													

Procedure Completed/Clinical Notes: _____

Post-Op Instructions D/C Criteria Met D/C Time _____ :

For Office Use Only:

Post-Op Call _____

Comment Card _____

Posted _____

Drug Log _____

1-wk. Post-Op Call _____