Republic of the Philippines
CAVITE STATE UNIVERSITY-CCAT
Cavite College of Arts and Trades Campus
Rosario, Cavite

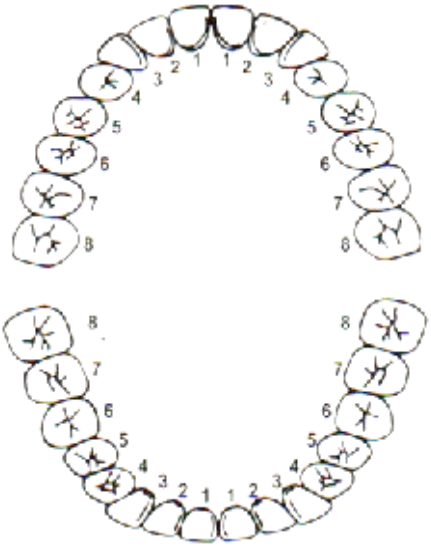
Dental Record Form

Name : _____

Address : _____

Sex : _____ Age : _____ Year : _____

DATE	DIAGNOSIS	TREATMENT



LEGEND:

C- Caries **M-** Missing

F- Filled **X-** For Extraction

P- Pontic **UN-** Unerrupted

RF- Root Fragment

(Back page of Dental Record Form...)

DATE	DIAGNOSIS	TREATMENT

Screening Health History:

1. Chief Complaint
2. History of Present Illness
3. Past Dental History
4. Medical History
   a. Are you under the care of a physician?
   b. Have you ever been hospitalized or any operations?
   c. Are you taking any drugs, medicines or pills of any kind?
   d. Do you have any allergies?
   e. Have you ever had any type of heart disease high blood pressure or rheumatic fever?
   f. Do you have diabetes?
   g. Have you ever had any bleeding problems?
   h. (Woman) Are you pregnant now?

_____ _____

Dentist Signature of px