



Patient record: Dental

Blank form to fill in by hand.

Clinic

Doctor

Date

____ / ____ / ____
dd/mm/yyyy

Essentials

First name

Last name

Date of birth

____ / ____ / ____
dd/mm/yyyy

Place of birth

Nationality

Profession

Phone number

Email

Address

Gender

☐ Female ☐ Male ☐ Non binary ☐ Prefer not to say

1. General Medical History

Allergies?

☐ Yes ☐ No

If yes, give details: _____

Heart disease or hypertension?

☐ Yes ☐ No

If yes, give details: _____

Diabetes or endocrine disorders?

☐ Yes ☐ No

If yes, give details: _____

Hepatitis (B, C) or HIV carrier?

☐ Yes ☐ No

If yes, give details: _____

Smoking or e-cigarettes?

☐ Yes ☐ No

If yes, give details: _____

Bleeding or clotting disorders?

☐ Yes ☐ No

If yes, give details: _____

Prescription medication?

☐ Yes ☐ No

If yes, give details: _____

☐ Yes ☐ No

Other conditions or medications

Chief complaint

Right																Left
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

Before treatment

Before photo date

____ / ____ / ____
dd/mm/yyyy

After treatment

Space for a photo or sketch

After photo date

____ / ____ / ____
dd/mm/yyyy

5. Radiographic Examination

Radiographs taken or provided?

☐ Yes ☐ No

If yes, give details: _____

Radiograph date

____ / ____ / ____
dd/mm/yyyy

Radiograph type

☐ Periapical ☐ Panoramic ☐ CBCT ☐ Bitewing

6. Informed Consent

Informed consent

1. I have been informed in an understandable way about my diagnosis, the purpose of the proposed treatment, the procedures that may be performed, reasonable alternatives, expected benefits, limitations and possible risks.
2. I have been informed that the outcome of treatment cannot be guaranteed absolutely and that additional procedures, check-ups or treatment may be needed depending on the clinical situation.
3. I have had the opportunity to ask questions, and I declare that the answers I received were sufficient for my decision.
4. I authorize the dentist and clinical staff to perform the agreed treatment and clinically necessary supporting procedures within the treatment plan discussed with me.
5. I have been informed that I have the right to refuse the treatment or to withdraw this consent at any time. Withdrawal does not affect procedures performed before it.

Patient or Legal Representative Signature

Doctor Signature

Date:

Date:

7. Record of Treatments

Treatments rendered

Tooth #	Diagnosis	Treatment & notes	Date

Signature

Date

____ / ____ / ____
dd/mm/yyyy