This is a sample, representative template, normally used in clinics. It can be fully customised as per requirement.

Doctor Name

BDS, MDS
Dental Surgeon

Your Hospital Name, Street Name,
Locality, Area, City, State, Pincode: 100XXX

+91-98XXXXXXX1

myemailid@gmail.com

Patient Name : **Date :**

UHID No. : **Age / Gender :** **Mob. :**

Chief Complaints:

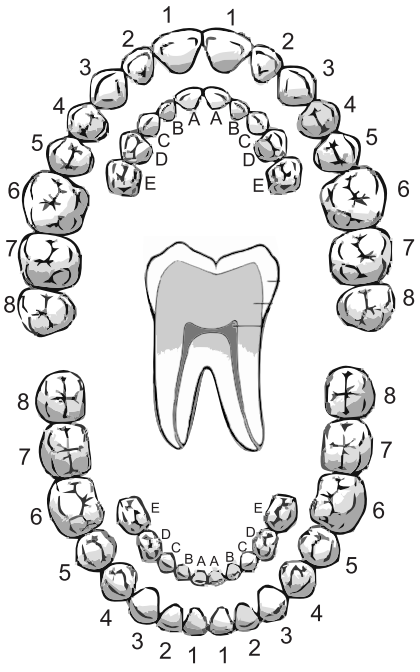
Medical History:

- [ ] Diabetes
- [ ] Hypertension
- [ ] Heart Disorder
- [ ] Thyroid Disorder
- [ ] Liver Disorder
- [ ] Kidney Disorder
- [ ] HIV / AIDS
- [ ] Allergy

Any Other:

Dental History:

℞



Signature:

Treatment Advised:

- ☐ X-Ray
- ☐ RCT
- ☐ Extraction
- ☐ Crown
- ☐ Restoration (GIC/Composite)
- ☐ Oral prophylaxis
- ☐ RPD/FPD
- ☐ Orthodontic t/t
- ☐ Implant
- ☐ Pedodontic t/t

Patient's Consent:

I hereby declare, that the doctor has explained to me in details about the treatment to be performed. I have also been informed about the side effects and complications that may arise due to treatment or due to use of local anaesthesia.

Patient's Signature: _____

TREATMENT PLAN AND SCHEDULE				
Date	**Treatment Performed**	**Payment**	**Balance**	**Sign**
DD / MM / YYYY				
NEXT VISIT DD / MM / YYYY				
NEXT VISIT DD / MM / YYYY				
NEXT VISIT DD / MM / YYYY				
NEXT VISIT DD / MM / YYYY				
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Doctor Name

BDS, MDS
Dental Surgeon

Your Hospital Name, Street Name,
Locality, Area, City, State, Pincode: 100XXX

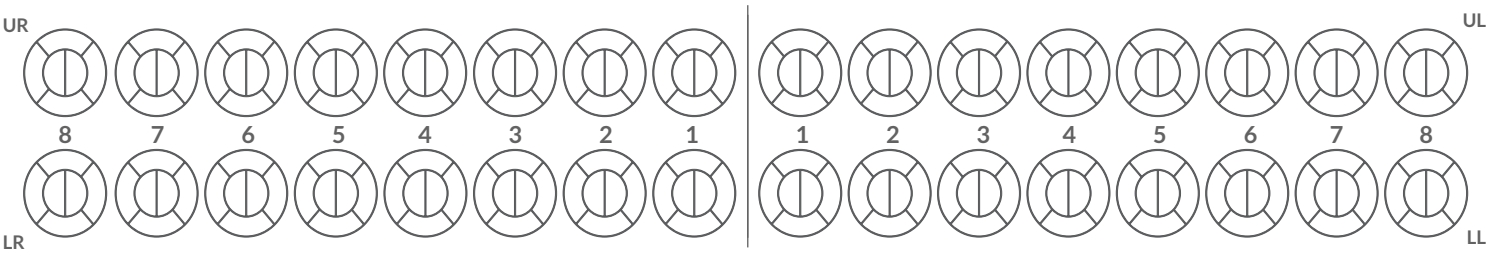
+91-98XXXXXXX1

myemailid@gmail.com

Patient Name : **Date :**

UHID No. : **Age / Gender :** **Mob. :**

Current Condition:



Chief Complaints:

Medical History:

On Examination:

Sr. No.:	Date	Work Done	Payment	Sign.

Doctor Name

MBBS, MD
Dentist

Your Hospital Name, Street Name,
Locality, Area, City, State, Pincode: 100XXX

+91-98XXXXXXX1

myemailid@gmail.com

Patient Name : **UHID No** :

Date/Time : **Age/Gender:** **Mobile No.** :

Consult. Start Time: _____ Allergic to: _____ Temp (°C): _____

Fall Risk Screening: _____ Nutri Screening: (if applicable) _____ Pain Score (0-10): _____

VITAL SIGNS (As applicable)

BP (mm/Hg): Sys _____ / Dias _____ Pulse (/min): _____ Height (cms): _____

Weight (kg): _____ Resp. Rate (/min): _____

CHIEF COMPLAINTS: ☐ Pain ☐ Decay ☐ Replace Missing Teeth ☐ Sensitivity

MEDICAL HISTORY: _____

ANY KNOWN ALLERGIES: _____

ORAL EXAMINATIONS & DIAGNOSIS:

1. Periodontium:
Stains ☐ + ☐ ++ ☐ +++
Calculus ☐ + ☐ ++ ☐ +++
Gingival Symptoms: _____

2. Missing:

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

3. Caries:

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

4. Existing Restorations:

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

5. Existing Prosthesis: ☐ PFM: _____ ☐ Full Ceramic: _____ ☐ Others: _____

INVESTIGATIONS:

- ☐ RVG
- ☐ OPG
- ☐ CBCT
- ☐ Cephalogram

Other Lab Tests & Imaging Advised

FINAL DIAGNOSIS: _____

TREATMENT PLAN: _____

TREATMENT DONE: _____

Admission Advised: If yes _____

Anesthesia Fitness: If yes _____

Surgery Advised: If yes _____

PRESCRIPTION

Sr. No.	MEDICINE (WRITE IN CAPITAL)	Dose	Morn	Noon	Night	Days

Doctor's Seal & Signature

FOLLOW UP DATE

DD / MM / YYYY

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Doctor Name

MBBS, MD
Dentist

Your Hospital Name, Street Name,
Locality, Area, City, State, Pincode: 100XXX

+91-98XXXXXXX1

myemailid@gmail.com

Patient Name :

UHID No :

Date/Time :

Age/Gender:

Mobile No. :

LAB TESTS ADVISED:

- [ ] Test 1
- [ ] Test 2
- [ ] Test 3
- [ ] Test 4
- [ ] Test 5
- [ ] Test 6
- [ ] Test 7
- [ ] Test 8
- [ ] Test 9
- [ ] Test 10

Other Lab Tests

IMAGING TESTS ADVISED:

- [ ] Test 1
- [ ] Test 2
- [ ] Test 3
- [ ] Test 4
- [ ] Test 5
- [ ] Test 6
- [ ] Test 7
- [ ] Test 8
- [ ] Test 9
- [ ] Test 10

Other Imaging Tests

Consult. Start Time: _____ Allergic to: _____ Temp (°C): _____

Fall Risk Screening: _____ Nutri Screening: _____ Pain Score (0-10): _____

VITAL SIGNS (As applicable)

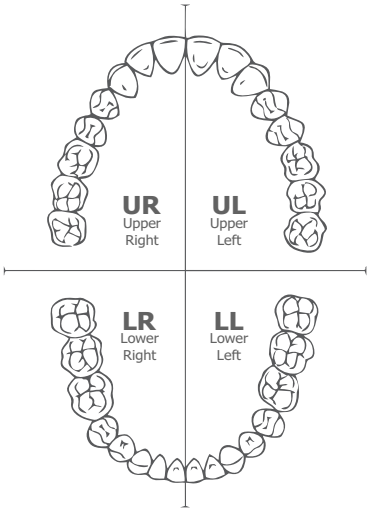
BP (mm/Hg): Sys _____ / Dias _____ Pulse (/min): _____ Height (cms): _____

Weight (kg): _____ Resp. Rate (/min): _____ Head Circum-pediatric (cms): _____

CHIEF COMPLAINTS & HISTORY:

RELEVANT PAST MEDICAL HISTORY:

CLINICAL EXAMINATION:



PROVISIONAL DIAGNOSIS:

PROCEDURE ADVISED:

PROCEDURE DONE:

SPECIAL INSTRUCTIONS:

Admission Advised: If yes

Surgery Advised: If yes

PRESCRIPTION

Sr. No.	MEDICINE (WRITE IN CAPITAL)	Dose	Morn	Noon	Night	Days

Doctor's Seal & Signature

FOLLOW UP DATE

DD / MM / YYYY