Medical Record Form - Dental Clinic

This **medical record form** sample is designed specifically for dental clinics to efficiently document patient history and treatment details. It ensures accurate record-keeping and enhances patient care by providing a comprehensive and organized format. Dental professionals can customize this form to meet their clinic's unique needs.

Patient Information

Full Name		**Gender**	
Date of Birth		**Phone Number**	
Address			
Emergency Contact Name		**Relationship**	
Emergency Contact Phone		**Email**	

Medical History

Are you currently under a physician's care?	Yes â˜ No â˜ If yes, please explain:
Do you have any allergies?	Yes â˜ No â˜ If yes, please list:
Are you taking any medications?	Yes â˜ No â˜ If yes, please list:
Have you ever had any major illnesses or surgeries?	Yes â˜ No â˜ If yes, please specify:
Do you smoke or use tobacco?	Yes â˜ No â˜
Women: Are you pregnant?	Yes â˜ No â˜ N/A â˜

Dental History

Date of Last Dental Visit	
Do you have dental pain or discomfort?	Yes â˜ No â˜ If yes, describe:
Have you had orthodontic treatment?	Yes â˜ No â˜
Do your gums bleed while brushing or flossing?	Yes â˜ No â˜
Do you grind your teeth?	Yes â˜ No â˜
Other dental concerns:	

Treatment Record

Date	Treatment Performed / Notes	Dentist / Hygienist

Patient/Guardian Signature		**Date**	
Dentist Signature		**Date**	