

**IHS DENTAL ENCOUNTER  
RECORD**

ADA CODE	EXPLANATIONS	ADA CODE	SURFACES/EXPLANATIONS	TEETH	ADA CODE	EXPLANATIONS	TEETH
<b>DIAGNOSTIC PROCEDURES</b>		<b>RESTORATIVE</b>			<b>PROSTHETICS</b>		
<input type="checkbox"/> D0120 Periodic Oral Eval <input type="checkbox"/> D0140 Limited / Problem Focused Eval. <input type="checkbox"/> D0150 Comprehensive Oral Eval. (D0180) <input type="checkbox"/> D0160 Detailed/Extensive Oral Eval. <input type="checkbox"/> D0220 PA X-rays - (1st film) # _____ <input type="checkbox"/> D0230 PA X-rays - (Addtl) #'s _____ <input type="checkbox"/> D0240 Intraoral Occlusal Film <input type="checkbox"/> D0272 Bitewings - 2 Films <input type="checkbox"/> D0274 Bitewings - 4 Films <input type="checkbox"/> D0330 Panoramic Film <input type="checkbox"/> D0460 Pulp Vitality Tests <input type="checkbox"/> D0470 Diagnostic Casts (per set ) <input type="checkbox"/> D0 _____ <input type="checkbox"/> D0 _____		<b>AMALGAM RESTORATIONS</b> <input type="checkbox"/> D21___ M O D B L _____ <input type="checkbox"/> D21___ M O D B L _____ <input type="checkbox"/> D21___ M O D B L _____ <input type="checkbox"/> D21___ M O D B L _____  <b>RESIN RESTORATIONS</b> <input type="checkbox"/> D23___ M O D F L I _____ <input type="checkbox"/> D23___ M O D F L I _____ <input type="checkbox"/> D23___ M O D F L I _____ <input type="checkbox"/> D23___ M O D F L I _____  <b>OTHER RESTORATIVE SERVICES</b> <input type="checkbox"/> D2920 Recement Crown _____ <input type="checkbox"/> D2930 SSC (primary) #'s _____  <input type="checkbox"/> D2940 Sedative Filling _____ <input type="checkbox"/> D2950 Core Buildup _____ <input type="checkbox"/> D2970 Temporary Crown _____ <input type="checkbox"/> D2 _____ <input type="checkbox"/> D2 _____			<b>REMOVABLE</b> <input type="checkbox"/> D5 _____ <input type="checkbox"/> D5 _____ <input type="checkbox"/> D5 _____  <b>FIXED</b> <input type="checkbox"/> D6 _____ <input type="checkbox"/> D6 _____ <input type="checkbox"/> D6 _____		
<b>PREVENTIVE</b>		<b>ENDODONTICS</b>			<b>ORAL SURGERY</b>		
<input type="checkbox"/> D1110 Prophylaxis - Adult <input type="checkbox"/> D1120 Prophylaxis - Child <input type="checkbox"/> D1201 Topical Fluoride w/ prophy - child <input type="checkbox"/> D1203 Topical Fluoride w/o prophy - child <input type="checkbox"/> D1204 Topical Fluoride w/o prophy - adult <input type="checkbox"/> D1205 Topical Fluoride w/ prophy - adult <input type="checkbox"/> D1320 Tobacco Counseling <input type="checkbox"/> D1330 Oral Hygiene Instruction <input type="checkbox"/> D1351 Sealant - #'s _____ <input type="checkbox"/> D1 _____ <input type="checkbox"/> D1 _____		<input type="checkbox"/> D3220 Vital Pulpotomy _____  <input type="checkbox"/> D3221 Gross Pulpal Debridement _____ <input type="checkbox"/> D32 _____ <input type="checkbox"/> D33 Endodontic Fill (Permanent) _____ <input type="checkbox"/> D3 _____ <input type="checkbox"/> D3 _____			<input type="checkbox"/> D7110 Simple, single _____ <input type="checkbox"/> D7120 Simple, addtl' _____ <input type="checkbox"/> D7210 Surgical, erupted _____ <input type="checkbox"/> D7220 Surgical, soft tissue _____ <input type="checkbox"/> D7230 Surgical, part. bony _____ <input type="checkbox"/> D7240 Surgical, comp. bony _____ <input type="checkbox"/> D7 _____ <input type="checkbox"/> D7 _____		
<b>PERIODONTICS</b>					<b>ORTHODONTICS</b>		
<input type="checkbox"/> D4341 Root Planing, per quadrant _____ <input type="checkbox"/> D4355 Full Mouth Debridement <input type="checkbox"/> D4910 Periodontal Maintenance (recall) <input type="checkbox"/> D4 _____ <input type="checkbox"/> D4 _____					<input type="checkbox"/> D8670 Periodic Ortho Trt. Visit _____ <input type="checkbox"/> D7 _____ <input type="checkbox"/> D7 _____		
					<b>OTHER SERVICES</b>		
					<input type="checkbox"/> D9110 Palliative Treatment _____ <input type="checkbox"/> D9215 Local Anesthesia _____ <input type="checkbox"/> D9310 Consultation _____ <input type="checkbox"/> D9630 Other drugs/med., by rpt. _____ <input type="checkbox"/> D9 _____ <input type="checkbox"/> D9 _____		

**PERSONS SERVED DATA & VARIABLE USE CODES**

<input type="checkbox"/> 0000 First Visit (once per yr)	<input type="checkbox"/> 9330 Hypertension Screening
<input type="checkbox"/> 0190 Patient Revisit	<input type="checkbox"/> 9990 Planned TX Completed
<input type="checkbox"/> 9130 Broken Appt.	<input type="checkbox"/> IH _____
<input type="checkbox"/> 9140 Canceled Appt.	<input type="checkbox"/> IH _____
<input type="checkbox"/> 9170 Emerg. Encounter	<input type="checkbox"/> IH _____
<input type="checkbox"/> 9320 Diabetic Screening	<input type="checkbox"/> IH _____

**EVALUATION CODES**

<input type="checkbox"/> IH70 No Codes Apply	<input type="checkbox"/> IH76 Missing Teeth due to Decay or Perio
<input type="checkbox"/> IH71 Caries Free Child	<input type="checkbox"/> IH77 Edentulous
<input type="checkbox"/> IH72 Untreated Decay	<input type="checkbox"/> 0003 BBTD/rampant caries
<input type="checkbox"/> IH73 Dental Sealant	<input type="checkbox"/> 0004 Headstart Visit
<input type="checkbox"/> IH74 Adequate Perio Health	<input type="checkbox"/> 9340 Prenatal Mother
<input type="checkbox"/> IH75 Destructive Perio Dis.	<input type="checkbox"/> 9341 Parent/Caregiver



**PATIENT IDENTIFICATION:**

Name: \_\_\_\_\_ Health Record: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Med. Hx:  Changed  No Change

BP: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_ Temp: \_\_\_\_\_

Behavior:  ++  +  -  --

Level of Understanding:  Good  Fair  Poor  Pt. Refused Education

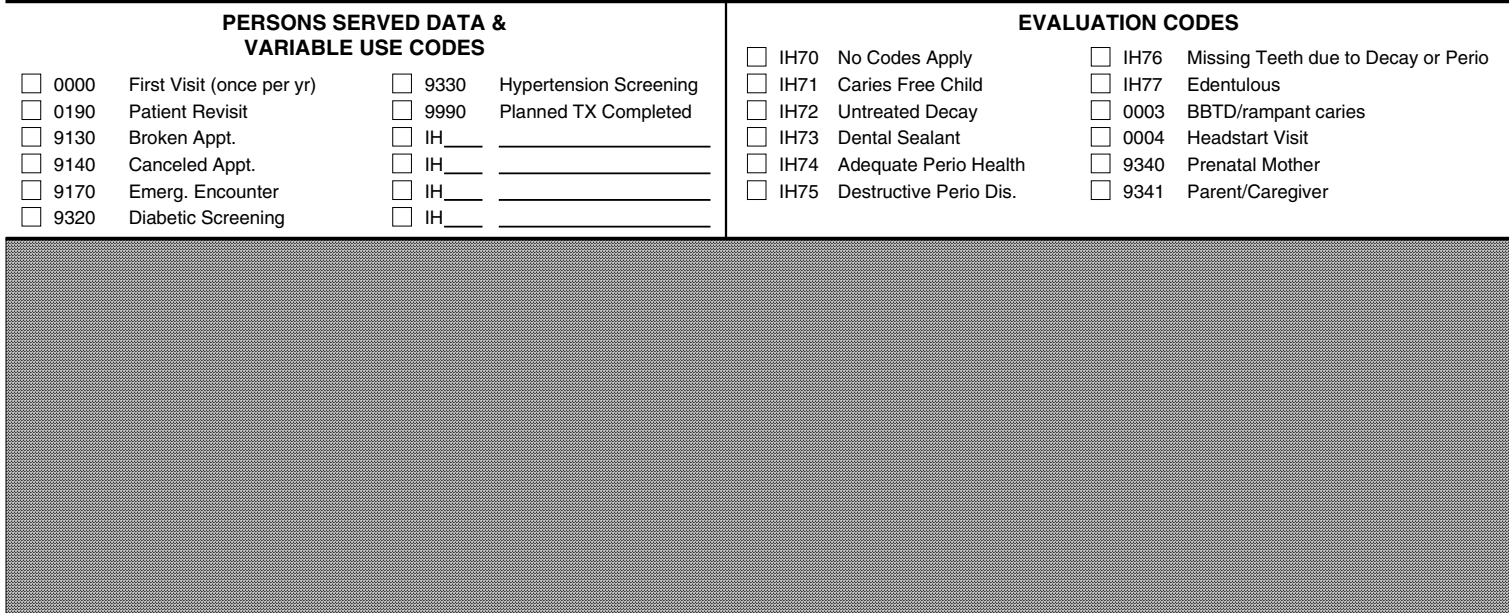
Next Visit: \_\_\_\_\_

DENTIST SIGNATURE \_\_\_\_\_ DATE OF VISIT \_\_\_\_\_ TIME OF VISIT \_\_\_\_\_

**DENTAL DATA ENTRY COPY**

**IHS DENTAL ENCOUNTER  
RECORD**

ADA CODE	EXPLANATIONS	ADA CODE	SURFACES/EXPLANATIONS	TEETH	ADA CODE	EXPLANATIONS	TEETH	
<b>DIAGNOSTIC PROCEDURES</b>		<b>RESTORATIVE</b>			<b>PROSTHETICS</b>			
<input type="checkbox"/> D0120	Periodic Oral Eval	<b>AMALGAM RESTORATIONS</b>			<b>REMOVABLE</b>			
<input type="checkbox"/> D0140	Limited / Problem Focused Eval.	<input type="checkbox"/> D21___	M O D B L	_____	<input type="checkbox"/> D5___	_____	_____	
<input type="checkbox"/> D0150	Comprehensive Oral Eval. (D0180)	<input type="checkbox"/> D21___	M O D B L	_____	<input type="checkbox"/> D5___	_____	_____	
<input type="checkbox"/> D0160	Detailed/Extensive Oral Eval.	<input type="checkbox"/> D21___	M O D B L	_____	<input type="checkbox"/> D5___	_____	_____	
<input type="checkbox"/> D0220	PA X-rays - (1st film) # _____	<input type="checkbox"/> D21___	M O D B L	_____	<b>FIXED</b>			
<input type="checkbox"/> D0230	PA X-rays - (Addtl) #'s _____	<b>RESIN RESTORATIONS</b>			<input type="checkbox"/> D6___	_____	_____	
<input type="checkbox"/> D0240	Intraoral Occlusal Film	<input type="checkbox"/> D23___	M O D F L I	_____	<input type="checkbox"/> D6___	_____	_____	
<input type="checkbox"/> D0272	Bitewings - 2 Films	<input type="checkbox"/> D23___	M O D F L I	_____	<input type="checkbox"/> D6___	_____	_____	
<input type="checkbox"/> D0274	Bitewings - 4 Films	<input type="checkbox"/> D23___	M O D F L I	_____	<b>ORAL SURGERY</b>			
<input type="checkbox"/> D0330	Panoramic Film	<input type="checkbox"/> D23___	M O D F L I	_____	<input type="checkbox"/> D7110	Simple, single	_____	
<input type="checkbox"/> D0460	Pulp Vitality Tests	<input type="checkbox"/> D23___	M O D F L I	_____	<input type="checkbox"/> D7120	Simple, addtl	_____	
<input type="checkbox"/> D0470	Diagnostic Casts (per set )	<b>OTHER RESTORATIVE SERVICES</b>			<input type="checkbox"/> D7210	Surgical, erupted	_____	
<input type="checkbox"/> D0_____	_____	<input type="checkbox"/> D2920	Recement Crown	_____	<input type="checkbox"/> D7220	Surgical, soft tissue	_____	
<input type="checkbox"/> D0_____	_____	<input type="checkbox"/> D2930	SSC (primary) #'s	_____	<input type="checkbox"/> D7230	Surgical, part. bony	_____	
<b>PREVENTIVE</b>		<input type="checkbox"/> D2940	Sedative Filling	_____	<input type="checkbox"/> D7240	Surgical, comp. bony	_____	
<input type="checkbox"/> D1110	Prophylaxis - Adult	<input type="checkbox"/> D2950	Core Buildup	_____	<input type="checkbox"/> D7_____	_____	_____	
<input type="checkbox"/> D1120	Prophylaxis - Child	<input type="checkbox"/> D2970	Temporary Crown	_____	<input type="checkbox"/> D7_____	_____	_____	
<input type="checkbox"/> D1201	Topical Fluoride w/ prophy - child	<input type="checkbox"/> D2_____	_____	_____	<input type="checkbox"/> D7_____	_____	_____	
<input type="checkbox"/> D1203	Topical Fluoride w/o prophy - child	<b>ENDODONTICS</b>			<b>ORTHODONTICS</b>			
<input type="checkbox"/> D1204	Topical Fluoride w/o prophy - adult	<input type="checkbox"/> D3220	Vital Pulpotomy	_____	<input type="checkbox"/> D8670	Periodic Ortho Trt. Visit	_____	
<input type="checkbox"/> D1205	Topical Fluoride w/ prophy - adult	<input type="checkbox"/> D3221	Gross Pulpal Debridement	_____	<input type="checkbox"/> D7_____	_____	_____	
<input type="checkbox"/> D1320	Tobacco Counseling	<input type="checkbox"/> D32_____	_____	_____	<input type="checkbox"/> D7_____	_____	_____	
<input type="checkbox"/> D1330	Oral Hygiene Instruction	<input type="checkbox"/> D33___	Endodontic Fill (Permanent)	_____	<b>OTHER SERVICES</b>			
<input type="checkbox"/> D1351	Sealant - #'s _____	<input type="checkbox"/> D3_____	_____	_____	<input type="checkbox"/> D9110	Palliative Treatment	_____	
<input type="checkbox"/> D1_____	_____	<input type="checkbox"/> D3_____	_____	_____	<input type="checkbox"/> D9215	Local Anesthesia	_____	
<input type="checkbox"/> D1_____	_____	<input type="checkbox"/> D3_____	_____	_____	<input type="checkbox"/> D9310	Consultation	_____	
<b>PERIODONTICS</b>		<input type="checkbox"/> D3_____	_____	_____	<input type="checkbox"/> D9630	Other drugs/med., by rpt.	_____	
<input type="checkbox"/> D4341	Root Planing, per quadrant _____	<b>PERSONS SERVED DATA &amp; VARIABLE USE CODES</b>			<input type="checkbox"/> D9_____	_____	_____	
<input type="checkbox"/> D4355	Full Mouth Debridement	<input type="checkbox"/> 0000	First Visit (once per yr)	<input type="checkbox"/> 9330	Hypertension Screening	<b>EVALUATION CODES</b>		
<input type="checkbox"/> D4910	Periodontal Maintenance (recall)	<input type="checkbox"/> 0190	Patient Revisit	<input type="checkbox"/> 9990	Planned TX Completed	<input type="checkbox"/> IH70	No Codes Apply	
<input type="checkbox"/> D4_____	_____	<input type="checkbox"/> 9130	Broken Appt.	<input type="checkbox"/> IH_____	_____	<input type="checkbox"/> IH76	Missing Teeth due to Decay or Perio	
<input type="checkbox"/> D4_____	_____	<input type="checkbox"/> 9140	Canceled Appt.	<input type="checkbox"/> IH_____	_____	<input type="checkbox"/> IH77	Edentulous	
		<input type="checkbox"/> 9170	Emerg. Encounter	<input type="checkbox"/> IH_____	_____	<input type="checkbox"/> 0003	BBTD/rampant caries	
		<input type="checkbox"/> 9320	Diabetic Screening	<input type="checkbox"/> IH_____	_____	<input type="checkbox"/> 0004	Headstart Visit	
					<input type="checkbox"/> IH71	Caries Free Child	<input type="checkbox"/> 9340	Prenatal Mother
					<input type="checkbox"/> IH72	Untreated Decay	<input type="checkbox"/> 9341	Parent/Caregiver
					<input type="checkbox"/> IH73	Dental Sealant		
					<input type="checkbox"/> IH74	Adequate Perio Health		
					<input type="checkbox"/> IH75	Destructive Perio Dis.		



**PATIENT IDENTIFICATION:**

Name: \_\_\_\_\_ Health Record: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Med. Hx:  Changed  No Change

BP: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_ Temp: \_\_\_\_\_

Behavior:  ++  +  -  --

Level of Understanding:  Good  Fair  Poor  Pt. Refused Education

Next Visit: \_\_\_\_\_

DENTIST SIGNATURE

DATE OF VISIT

TIME OF VISIT

**BILLING OFFICE COPY**

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**PROGRESS NOTES (continued):** \_\_\_\_\_

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Dentist's Initials:
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