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| **MUNICIPIO** | **VEREDA** | **N° H.CL.** | | | |
| **NOMBRE DEL PROFESIONAL** | | AÑO | MES | DÍA | HORA |

**1. IDENTIFICACIÓN**

**DATOS DEL PACIENTE**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1er APELLIDO | | 2do. APELLIDO | | | NOMBRES | |
|  | |  | | |  | |
| TIPO Y N° DE IDENTIFICACIÓN | | FECHA DE NACIMIENTO | | | EDAD | ESTADO CIVIL |
|  |  | AÑO | MES | DÍA |  |  |
| DIRECCIÓN (Residencia- Municipio) | | BARRIO – CIUDAD ( Vereda) | | | TELÉFONO / CELULAR | |
|  | |  | | |  | |
| OCUPACIÓN ( profesión u oficio) | | ENTIDAD DONDE LABORA | | | DIRECCIÓN /TELÉFONO | |
|  | |  | | |  | |

**TIPO DE AFILIACION EPS:**

|  |  |  |
| --- | --- | --- |
| CONTRIBUTIVO | SUBSIDIADO | OTRO |

**DATOS DEL RESPONSABLE DEL PACIENTE**

|  |  |  |
| --- | --- | --- |
| 1er APELLIDO | 2do. APELLIDO | NOMBRES |
|  |  |  |
| PARENTESCO | DIRECCIÓN CIUDAD-BARRIO | TELÉFONO / CELULAR |
|  |  |  |

**2. MOTIVO DE LA CONSULTA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. ENFERMEDAD ACTUAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4. ANTECEDENTES MEDICOS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5. HALLAZGOS ODONTOLOGICOS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**HIGIENE ORAL**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Higiene Oral | Buena |  | Regular |  | Mala |  |
| Frecuencia diaria de Cepillado | Una Vez |  | Dos Veces |  | Tres Veces |  |
| Uso Diario de Seda Dental | Una Vez |  | A Veces |  | Nunca |  |

**INDICE DE PLACA BACTERIANA:**

Índice de Placa O¨leary \_\_\_\_\_\_\_\_\_\_ N° de Superficies Teñidas\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X 100 = \_\_\_\_\_\_\_\_\_ %

N° Superficies. Dentales presentes (4 por diente)

**ÍNDICE COP = CARIADOS: \_\_\_\_\_\_\_\_\_\_\_\_\_OBTURADOS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_PERDIDOS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ =**

**6. PLAN DE TRATAMIENTO DE PROMOCION y MANTENIMIENTO (Según la Resolución 3280 de 2018)**

|  |  |  |  |
| --- | --- | --- | --- |
| **ACTIVIDAD DE PROMOCION y MANTENIMIENTO** | **SI** | **NO** | **OBSERVACIONES** |
| **VALORACION INTEGRAL** |  |  |  |
| **CONTROL DE PLACA** |  |  |  |
| **FLUOR** |  |  |  |
| **SELLANTES** |  |  |  |
| **DETARTRAJE** |  |  |  |

**PLAN DE TRATAMIENTO ODONTOLOGICO**

|  |  |
| --- | --- |
| **ACTIVIDAD** | **QUE ACTIVIDADES SE REALIZARAN** |
| **OPERATORIA (RESINAS)** |  |
| **EXODONCIA** |  |

|  |  |
| --- | --- |
|  | **7. ODONTOGRAMA INICIAL**  **S**  SUPERFICIE  OBTURADA  CARIES O  RECIDIVA  EXTRACCION  INDICADA  DIENTE  EXTRAIDO  SIN  ERUPCIONAR  EROSION  ABRASION  CON  ENDODONCIA  HACER  ENDODONCIA  PROTESIS  CORONA  TIENE  SELLANTE  HACER  SELLANTE    18  17  16  15  14  13  12  11  55  54  53  52  51  48  47  46  45  44  43  42  41  85  84  83  82Y  81  21  22  23  24  25  26  27  28  61  62  63  64  65  31  32  33  34  35  36  37  38  71  72  73  74  75  I  D  VESTIBULAR  VESTIBULAR  LINGUAL |
|  | |  |  |  |  | | --- | --- | --- | --- | | **8. DIAGNOSTICO** | 1. | **9. PRONOSTICO** | 1. BUENO | | 2. | 1. REGULAR | | 3. | 1. MALO | |

**10. DESCRIPCIÓN DEL TRATAMIENTO EJECUTADO**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **FECHA** | **HORA LLEGADA** | **HORA**  **SALIDA** | **DIENTE** | **SUPERFICIE** | **DESCRIPCIÓN DEL PROCEDIMIENTO** | **NOMBRE ODONTÓLOGO** | **FIRMA PACIENTE** |
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