Gandhis Dental Care

PART 1: Medical History & General terms and Conditions

Name: **ID # :**

Date :

Father / Husband Name:

Age Years Sex: Male / Female (tick) Marital Status: Married / Single(tick)

Address:

City: **State:** **Pin:**

Phone :

Mobile 1 :

Mobile 2 :

Email :

Profession :

Emergency contact name and number:

How would you like us to contact you?

Kindly tick your choices

	Do Not Call	Email	Work Phone	Home Phone	Mobile
To Contact					

DOB :

Anniversary :

Please answer each question:

When was the last time you saw your physician or a local doctor, and why?

1. Who is your family physician MBBS or a general doctor for general health?

   Name_____Address_____

   _____Phone_____

2. Would you describe your health as: Excellent / Good / Fair / Poor (Kindly tick)
3. Have you ever been hospitalized? Yes No
4. Have you ever fainted in dental Office Yes No
5. Do you have severe, frequent. Or migraine headaches? Yes No
6. Are you nervous about dental treatment? Yes No
7. Have you ever been unconscious? Yes No
8. Have you ever had a convulsion or a seizure or fits? Yes No
9. Have you any of the lung problems:
   - Coughing up blood? Yes No
   - Coughing or wheezing? Yes No
   - Asthma? Yes No
   - Bronchitis or continuous coughing? Yes No
   - Emphysema or fluids filling in the lungs? Yes No
10. Do you ever experience shortness of breath? Yes No
11. Do you ever have trouble in breathing? Yes No
12. Have you had any of the following heart problems:

Heart attack?	Yes	No	Chest pains?	Yes	No
Angina pain?	Yes	No	High blood pressure?	Yes	No
Swollen ankles?	Yes	No	Heart palpitations or sounds?	Yes	No
Stroke?	Yes	No	Murmur (heart sounds?	Yes	No

13. Have you had rheumatic fever(severe fever with swelling and pain in joints)? Yes No
    a) If yes, did your physician inform you of heart damage? Yes No
14. Have you had heart or vascular (blood vessels) surgery? Yes No
15. Have you had prolonged bleeding from cut, tooth extraction, nose bleed, Menstrual period, or other injury? Yes No
16. Do you have frequent nosebleeds? Yes No
17. Have you had gastric (stomach) ulcer? Yes No
18. Have you ever had any venereal or sexually transmitted disease? Yes No
19. Have you ever been diagnosed with Herpes? Yes No
20. Are you HIV positive or have AIDS? Yes No
21. Are you Diabetic? Yes No
22. Have you had thyroid problems? Yes No
23. Have you had hepatitis, yellow jaundice, or liver problems? Yes No
24. Have you had any of the following kidney problems:
    - Frequent infections? Yes No
    - Blood in urine? Yes No
    - Chronic renal failure? Yes No
    - Dialysis? Yes No
25. Do you have history of suffering from tuberculosis (TB) in any form Yes No
26. **Are you allergic or have you had adverse reaction to anaesthetic, antibiotic Or other drug? If yes list and describe all medicines or agents.** Yes No

Please turn over

27	Are you on any special diet?	Yes	No
28	If female, is there a possibility that you are pregnant?	Yes	No
29	Please list all medications and dose you take including aspirin, ecosprin, birth control pills etc Including steroids or homeopathy.		
30	Describe any other medical conditions that have not been mentioned above.		

General Terms and Conditions

1. The information provided above will be kept confidential.
2. Please ask about anything you do not fully understand or wish to have explained in more detail.
3. At any stage during or before the treatment, the doctor can refer you or get in touch with your physician regarding written consent / opinion on your present illness.
4. You will be given an opportunity to discuss your dental procedure(s) including the risk involved and consequences of no treatment at all, in detail with the doctor.
5. If deemed necessary, specific informed consent would be obtained from you for specialised procedures only.
6. Your records, including the radiographs and photographs are the belongings of this clinic and the copies of the same if required, could be obtained on authorization at additional cost.
7. Perfect results for any procedure are not guaranteed or warranted.
8. Rescheduling of appointments should be preferably carried out at least 24 hour before.
9. Full fee for the procedure(s)is payable before the commencement of the treatment.

By signing below, I do hereby declare that I have carefully read and agree to the general terms and conditions. I have also provided the information regarding my medical history to best of my knowledge and not concealed any facts. I also agree that I will voluntarily bring to the knowledge of the doctor any change in my medical status.

Date:

Place:

Signature: Patient or Parents (in case of minor)

PART 2: Informed Consent

Important Note: Kindly provide informed consent by signing below only after your examination, counselling and meeting with the doctor

1. I provide my consent to the Doctor(s) to carry out any routine dental diagnostic or therapeutic treatment procedures required to treat may condition(s).
2. The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of procedure to be in the language that I best understand and also agree that perfect results for any procedures are not guaranteed or warranted.
3. I have been informed, the possible alternative methods of treatment including no treatment at all in the language that I best understand.
4. I have been informed of the amount of the full fee of the procedure(s) payable by me towards my treatment and agree to pay before the commencement of the treatment.
5. The doctor has explained to me in detail that there is certain inherent and potential risk(s) in any treatment plan or procedure(s) including the one associated with the use of local anaesthesia.
6. I have been given an adequate opportunity to question the doctor concerning the nature of treatment, inherent risk(s) of the treatment, and the alternatives to the treatment.
7. This consent form does not include the entire scope of comprehensive discussion; that I had regarding the proposed treatment with doctor in detail.
8. In consideration to the above I authorize and provide the consent to the Doctor(s), and any other agents or employees of Gandhis Dental Care, and such assistant(s) as may be selected by them to treat me to best of their ability.

Date:

Place:

Signature: Patient or Parents (in case of minor)