**NEW PATIENT CASE HISTORY FORM**

***Dr. Deepika's***
***CROWNING SMILES***
**Implant & Cosmetic Dental Clinic**

**Case No. _____**

## Personal details:

Name: _____

Gender: _____ Age: _____ Birthdate: _____

Address:_____

_____

_____ Pincode:_____

Email address:_____

Contact details: (M) _____(O)_____(R)_____

Occupation: _____

**In Case of Emergency Contact Details:**

Emergency contact: Name _____Number_____

Relationship with the patient:_____

Family physician's Name _____ Number _____

In case the patient is under 18yrs of age, Please write the Parents/Guardians Names & Sign:

_____

_____

**How did you hear about us?**

- An existing patient
- Friends/ Family
- Dental camp
- Board outside our clinic
- BNI
- Google Map
- Google Business
- Banner/ signage
- Newspaper
- Magazine
- Flyer
- Website
- Face book
- You-tube

## MEDICAL AND DENTAL HISTORY

It is important that you answer questions accurately as this may affect your treatment.

**Have you had / do you suffer from:** *Please Tick If Yes*

| | |
|---|---|
| ○ COVID-19<br>○ CANCER<br>○ DRUG ABUSE<br>○ HIV/AIDS<br>○ HEPATITIS<br>○ HERPES<br>○ SYPHILLIS<br>○ TB<br>○ RADIATION THERAPY<br>○ CHEMOTHERAPY | ○ REQUIRED FREQUENT BLOOD TRANSFUCION<br>○ HAVE BLOOD DISORDES<br>○ EXCESSIVE BLEEDING<br>○ POOR HEALING OF WOUNDS<br>○ CORTICOSTEROID THERAPY<br>○ FAINTING/BLACKOUTS<br>○ FREQUENT MOUTH ULCERS<br>○ ACIDITY<br>○ ALLERGIES<br>○ ANXIETY<br>○ SINUSITIS |
| ○ AUTOIMMUNE DISORDERS<br>○ ALZIEHMERS<br>○ PARKINSONS DISEASE<br>○ MIGRAINE/ TENSION HEADACHES<br>○ PSYCHIATRIC TREATMENT/ THERAPY<br>○ STROKE | ○ DIABETES<br>○ EPILEPSY<br>○ THRYROID DISEASE<br>○ |
| ○ HIGH /LOW B.P<br>○ HEART PROBLEMS<br>○ PACEMAKERS | ○ ASTHAMA<br>○ BRONCHITIS |
| ○ JAUNDICE<br>○ LIVER DISEASE | ○ NEPHROTIC SYNDROME<br>○ KIDNEY DISEASE |
| ○ GASTRITIS<br>○ ULCERS (STOMACH/INTESTINE/ COLON)<br>○ GOUT | ○ INTESTINAL DISORDERS / ULCERATIVE COLITIS/ IRRITABLE BOWEL SYNDROME/ INDIGESTION |
| ○ GOUT<br>○ ARTHRITIS | ○ ARTIFICIAL JOINTS |

**FEMALES:** *Please Tick If Yes*

( ) MENOPAUSE ( ) OVARIAN DISEASE ( ) PCOS

( ) ONGOING ORAL CONTRACEPTIVE MEDICATION ( ) PREGNANT - DUE DATE: ( ) LACTATING

**ALLERGIC TO:** *Please Tick If Yes*

( ) PENICILLIN ( ) AMOXYCILLIN ( ) SULPHA ( ) ASPIRIN ( ) IODINE

( ) LIGNOCAINE ( ) ARTICAINE ( ) ANAESTHETIC ( ) IBUPROFEN ( ) STEROIDS

DO YOU CARRY A MEDICAL WARNING CARD: YES/NO

**ONGOING/ PAST MEDICATION:** *Please Tick If Yes*

( ) ASPIRIN ( ) WARFARIN ( ) ECOSPORIN ( )BISPHOSPHONATE

( ) OTHER BLOOD THINING/ ANTICOAGULANTS_____

( ) BRONCHODILATOR/ INHALER/ SALBUTAMOL_____

( ) OTHERS_____

**ONGOING/ PAST HOSPITALIZATION OR SURGERY:** *Please Tick If Yes*

( ) ACCIDENT

( ) SURGERY

( ) HEART ATTACK

( ) BYPASS/ ANGIOGRAPHY

( ) OTHERS_____

**HABITS:** *Please Tick If Yes*

| | ( ) PAN/ GUTKA | ( )SMOKING | ( ) ALCOHOL | ( ) TOBACCO | ( ) TEETH GRINDING | ( ) CENCHING |
|---|---|---|---|---|---|---|
| SINCE WHEN | | | | | | |
| FREQUENCY | | | | | | |

## DENTAL HISTORY AND QUESTIONAIRE

**PAST TREATMENTS:**

| Filling | Root canal | Cap/ bridge | Cosmetic/ smile design<br>Orthodontics | Gum therapy | Extraction | Implant | Sinus lift | Bone augment/ reduction |
|---|---|---|---|---|---|---|---|---|
| Did you experience in the past : Excessive bleeding / delayed healing/ dry socket/ allergy<br>Any concerns/ complications with the above treatments | | | | | | | | |

**YOUR REASON TO VISIT US TODAY:**_____

_____

_____

**DENTAL HEATH & SMILE QUESTIONAIRE**: *Please Tick If Applicable*

( ) I would like whiter teeth

( ) replace missing teeth

( ) I want better shape of teeth

( ) I want longer/ shorter tooth

( ) I want straighter teeth

( ) I want less gum showing when I smile

( ) I have to cover my mouth when I smile

( ) I want to remove gaps between my teeth

( ) I have a click in my jaw while eating

( ) I have discomfort while chewing

( ) I suffer from dry mouth

( ) I have had dental/ jaw accident in past

( ) Concerned I can't afford the dentistry I require

( ) I hate my black/ old fillings

( ) I want to improve color /remove tooth discoloration

( ) I am worried about broken/ cracked tooth

( ) My gums are at different levels & I need correction

( ) I wish I showed more teeth while smiling

( ) I wish my dentures fitted better

( ) I suffer from headache/ Jaw pain or fatigue

( ) My jaw dislocates

( ) I clench /grind teeth

( ) I suffer from bad breath

( ) I wish to modify my jawline

# General Consent Form:

**I hereby authorise and request the performance of dental services for myself or _____ age__ I agree to be examined and give my consent to any advisable and necessary medical/dental treatments, procedures, medications or anaesthetics to be administered by the attending doctor/dentist for diagnostic or treatment purposes. I understand & agree that during treatment, it may be necessary to change or add procedures because of the conditions that may be found while working/treating that may not be evident during examination. I understand & acknowledge that I am financially responsible for the services that are provided for myself or named & agree to abide by the payment policy. I give consent for taking my photographs/ videos for hard & soft copy records in the clinics files & on their website or education.**

**COVID-19 Pandemic Dental Treatment Consent Form**

I, _____, knowingly and willingly consent to have dental treatment Completed during the COVID-19 pandemic.

1. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not, given the current limits in virus testing.

2. If I am an asymptomatic carrier or an undiagnosed patient with COVID 19, I suspect it may endanger doctors and clinic staff. It is my responsibility to take appropriate precautions and to follow the protocols prescribed by them.

3. I am aware that I may get an infection from the clinic or from a doctor, and I will take every precaution to prevent this from happening, but I will not at all hold doctors and clinic staff accountable if such infection occurs to me or my accompanying persons.

4. In case I or my attendant get the COVID 19 infection after the visit to the clinic, I will inform the clinic authorities at the earliest, so that appropriate tracking of the patients/attendants and clinic staff present on the day of my visit can be done.

5. I confirm that I am not presenting any of the following symptoms of COVOID-19 listed below:

a - Fever
b - Shortness of Breath
c - Loss of Sense of Taste or Smell
d - Dry Cough
e - Runny Nose
f - Sore Throat

Initials- _____

6. I understand the government recommends social distancing of at least 6 feet for a period of 14 days to anyone who has shown symptoms or tested positive.

7. I verify that I have not travelled outside of India in the past 14 days to countries that have been affected by COVID-19.

8 I verify that I have not travelled domestic within India by commercial airline, bus, or train within the past 14 days.

9. I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to treatment completed during the COVID-19 pandemic. If I hide my facts and relevant details and because of my knowing or unknowing behaviour or action the clinic staff gets infected, I may be held responsible for appropriate compensation in the court of law.

Name:_____ Sign/Thumb impression: _____

Date:_____