



DENTISTREE DENTAL CLINIC

File No:

455

Name: <u>Bhyami Dholakia</u>	Mobile no.: <u>0506503490</u>	Email:
Date of Birth: <u>15/08/2016</u>	Sex: <input type="radio"/> M <input checked="" type="radio"/> F	Nationality: <u>British</u>
How do you know about us?	<input type="radio"/> Family or Friends <input type="radio"/> Internet <input type="radio"/> Newspapers <input type="radio"/> Others	

MEDICAL HISTORY

Certain medical conditions can affect dental treatment and vice versa.

Please complete this form by answering the questions.

Chief Complaint: Checkup

All details will be strictly confidential.	Yes	No	Others, Please Specify
Are you under a physician's care now?		<input checked="" type="checkbox"/>	
Are you taking any medications, pills, or drugs?		<input checked="" type="checkbox"/>	
Have you ever been hospitalized or had a major operation?		<input checked="" type="checkbox"/>	
Have you ever had any complications following dental treatment?		<input checked="" type="checkbox"/>	
Are you a smoker?		<input checked="" type="checkbox"/>	

Do you have, or have you had any of the following

<input type="radio"/> High Blood Pressure	<input type="radio"/> Low Blood Pressure	<input type="radio"/> Rheumatic Fever	<input type="radio"/> Fainting / Seizures
<input type="radio"/> Asthma	<input type="radio"/> Heart Attack	<input type="radio"/> Epilepsy	<input type="radio"/> Leukemia
<input type="radio"/> Heart Disease	<input type="radio"/> Kidney Disease	<input type="radio"/> Liver Disease	<input type="radio"/> Lung Disease
<input type="radio"/> Thyroid Problem	<input type="radio"/> Diabetes	<input type="radio"/> Tuberculosis	<input type="radio"/> Hepatitis/Jaundice
<input type="radio"/> Stroke	<input type="radio"/> Arthritis	<input type="radio"/> Cancer	<input type="radio"/> AIDS/HIV Infection
<input type="radio"/> Creutzfeldt-Jakob disease (CJD) <input type="radio"/> Others, Please Specify <u>NA</u>			

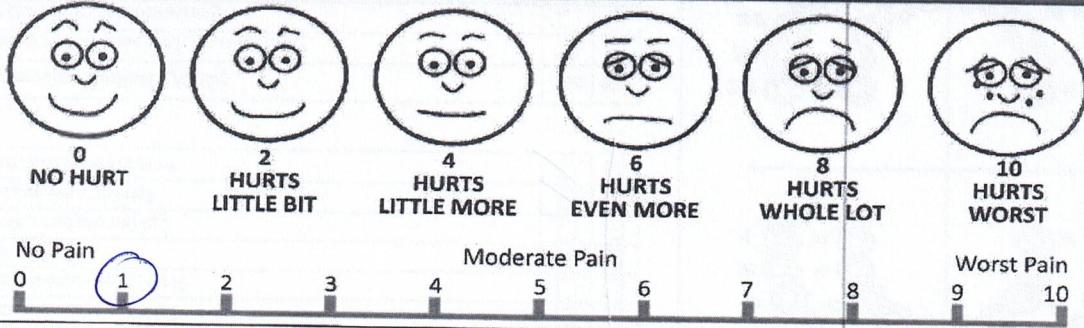
Are you allergic, or have you reacted adversely to any of the following:

Local anesthetics (Novocaine)	Yes	No	Others, Please Specify
Penicillin or other antibiotics		<input checked="" type="checkbox"/>	
Aspirin or Ibuprofen		<input checked="" type="checkbox"/>	
Reactions to metals		<input checked="" type="checkbox"/>	
Latex or rubber dam		<input checked="" type="checkbox"/>	
Foods		<input checked="" type="checkbox"/>	

Additional questions for women.

Are you pregnant or trying to get pregnant?	Yes	No	Others, Please Specify
if yes, expected delivery date: _____			
Are you taking oral contraceptives?			

PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY



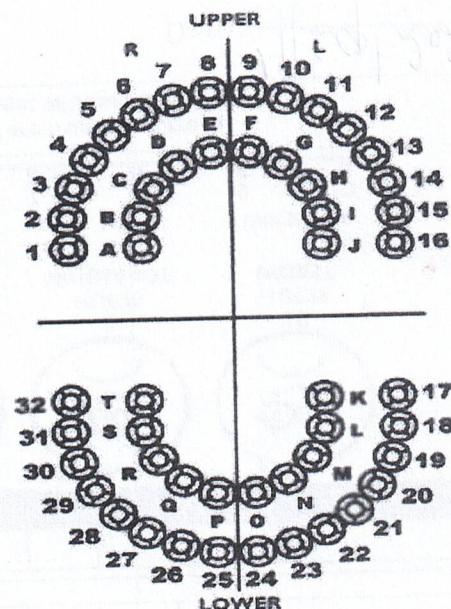
To the best of my knowledge, all of the preceding answer and information provided are true and correct.
If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Signature: Rajadholaia

Date: 4/9/2025

Oral Health Information Adult

	Yes	No
Do you gag easily?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you wear dentures?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Does food catch between your teeth?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you have difficulty in chewing your food?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you chew on only one side of your mouth?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do your gums bleed easily?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do your gums bleed when you floss?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do your gums feel swollen or tender?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Are your teeth sensitive?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you take fluoride supplements?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you prefer to save your teeth?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Do you want complete dental care?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

DENTAL CHARTING

Oral Health Information Pediatric/Child

	Yes	No
Does your child use a toothpaste with fluoride in it?	<input type="checkbox"/>	<input type="checkbox"/>
Do you help your child with toothbrushing?	<input type="checkbox"/>	<input type="checkbox"/>
Have your child experience in a dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have your child ever had cavities?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child complain of mouth pain?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child take a bottle to bed?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child loves to eat foods like Chocolates, candy, snacks a lot?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child gums bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>

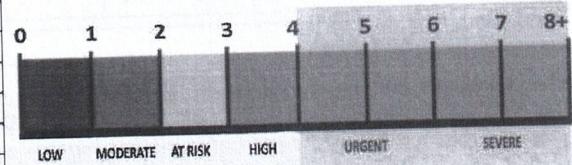
Health Information for TMJ

	Yes	No
Do you clench or grind your jaws frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Do your jaws ever feel tired?	<input type="checkbox"/>	<input type="checkbox"/>
Does your jaw get stuck so that you can't open freely?	<input type="checkbox"/>	<input type="checkbox"/>
Does it hurt when you chew or open wide to take a bite?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have earaches or pain in front of the ears?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any jaw headaches upon awaking in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find jaw pain or discomfort extremely frustrating /depressing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a temporomandibular (jaw) disorder (TMD)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	<input type="checkbox"/>	<input type="checkbox"/>
Are you unable to open your mouth as far as you want?	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of an uncomfortable bite?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a blow to the jaw (trauma)?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a habitual gum chewer or pipe smoker?	<input type="checkbox"/>	<input type="checkbox"/>

Category	0 = healthy	1 = changes	2 = unhealthy	Score
Lips	Smooth, Pink, Moist	Dry, chapped, red at corners	Swelling or lump ulcerated at corners	
Tongue	Normal, Moist, Pink	Patchy, fissured, red, coated	Patch that is red & ulcerated, swollen	
Gums & Tissues	Pink, Moist, Smooth	Dry, shiny, rough, swollen 1 to 6 teeth	Swollen, bleeding Generalized redness	
Saliva	Moist Tissues, Watery	Dry, sticky tissue, Little saliva present	No saliva present Tissues parched	
Natural Teeth	No Decayed/ Broken Teeth	1 to 3 decayed / 1 broken teeth	4 or more decayed & broken teeth	
Denture(s)	No Broken Areas	1 Broken Area	More than 1 broken	

FALL RISK ASSESSMENT

Falls are common for 65yrs of age and older.	Points	Yes	No
Do you fallen in the pass years?	2	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Are you using or advice to use cane or walker?	2	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Are you lose a balance while walking?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
You Worry about falling?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you use your arm/s to push your self from a chair?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you have trouble stepping up onto a curb/steps?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Are you sways when standing stationary?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you take short narrow step?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Are you stumble often or look at the ground when you walk?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you frequently have to rush to the toilet?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you have lost some feeling in one or both of your feet?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you take any medication to feel light headed or sleepy?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	14	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Total Points			

**YOUR
FALL RISK →**


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United Arab Emirates





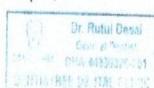
General Consent Form - Registration

Patient Name	Dhyani Dholakia			Emirates ID	784-2016-7715653-7
File No	455	DOB	2016-08-15	Nationality	British
Gender	Female	Doctor's Name	Rutul Desai	Date	2025-09-04

I consent to the examination, tests, and treatments, which may be done by the physician and assistant staff during my course of therapy. I understand I have to inform my personal and medical details and have the right to be informed about my treatment. I understand that the Center is not responsible for my personal property, money, or valuable left unattended. I authorize the Center to release information about my treatment: a.) as required to process payment of claims and (b) to other facilities or providers for the continuity of my care. In consideration of the services provided at the centre, I agree to pay the centre for all services provided to me. If any health insurance programs cover my treatment, I authorize the centre to bill any such insurer for all medical services provided, and agreed to pay any co-payment or charges not covered by my health insurance. This consent form will be stored in the patient's medical record at the clinic. I have read and understand the information on this sheet.

أوافق أنا الموقع أدناه على كل الفحوصات والاختبارات المعملية ، وعلى خطط العلاج التي يجريها لي الأطباء والأخصائيون والفريق الطبي المرافق بالمركز الطبي طوال فترة علاجي ، وأعلم جيداً أنني يجب أن أبلغ الأطباء والعاملين بالمركز كل التفاصيل الخاصة بي وأهمها التفاصيل الطبية ، كما أن من حقي معرفة أسلوب وخطة العلاج الخاصة بي، كما أعلم أن المركز الطبي (العيادة) ليست مسؤولة عن حالي الخاصة كالأموال وأي متعلقات خاصة بي لم اقم بحفظها ، وأنا أخول المركز (العيادة) بإبلاغ أي معلومات عن علاجي إلى الجهات الخاصة بتغطية نفقات العلاج ، أو الجهات الطبية التي قد تتولى تكميله علاجي فيما بعد ، وذلك إذا طلب منا ذلك. أقر بالموافقة على تسديد جميع نفقات علاجي بالمركز إما بالدفع الفوري أو بتحويل المركز (العيادة) بارسال فاتورة علاجي إلى التأمين الصحي التي انتمي إليها ، كما انعهد بدفع أي مصاريف إضافية غير مغطاه من شركات التأمين ، هذا الإقرار سيتم حفظه في الملف الطبي الخاص بالمريض، أقر بأنني قد قرأت وفهمت كل ما جاء في هذا الإقرار.

Sign here, only if all of your questions have been answered to your satisfaction

PATIENT	WITNESS	DENTIST
		 
Patient Name Dhyani Dholakia Date 2025-09-04	Date 2025-09-04	Dental Date 2025-09-04