



Name: ARSH PUNITKUMAR JAGADA			
Mobile no.: 050550 5327		Email: jo@primeworldwide.com	
Date of Birth: 24/6/2003		Sex: ☒ M ☐ F	Nationality: IND
How do you know about us? ☐ Family or Friends ☐ Internet ☐ Newspapers ☐ Others			

MEDICAL HISTORY

Certain medical conditions can affect dental treatment and vice versa.

Please complete this form by answering the questions.

Chief Complaint: ~~None~~ Food keeps getting stuck in the back & it hurts, some teeth hurt

All details will be strictly confidential.

Are you under a physician's care now?

Are you taking any medications, pills, or drugs?

Have you ever been hospitalized or had a major operation?

Have you ever had any complications following dental treatment?

Are you a smoker?

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

- | | | | |
|---|--|--|---|
| ☐ High Blood Pressure | ☐ Low Blood Pressure | ☐ Rheumatic Fever | ☐ Fainting / Seizures |
| ☐ Asthma | ☐ Heart Attack | ☐ Epilepsy | ☐ Leukemia |
| ☐ Heart Disease | ☐ Kidney Disease | ☐ Liver Disease | ☐ Lung Disease |
| ☐ Thyroid Problem | ☐ Diabetes | ☐ Tuberculosis | ☐ Hepatitis/Jaundice |
| ☐ Stroke | ☐ Arthritis | ☐ Cancer | ☐ AIDS/HIV Infection |
| ☐ Creutzfeldt-Jakob disease (CJD) | | ☐ Others, Please Specify | |

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

Local anesthetics (Novocaine)

Penicillin or other antibiotics

Asperin or Ibuprofen

Reactions to metals

Latex or rubber dam

Foods

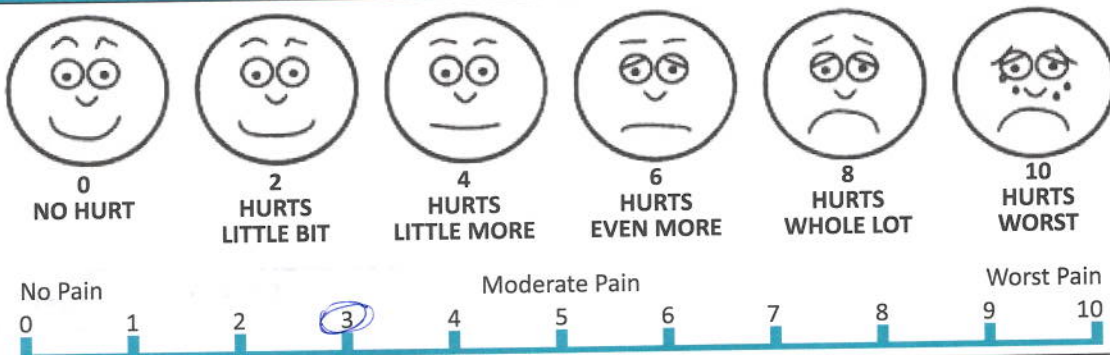
Additional questions for women.

Are you pregnant or trying to get pregnant?

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 of Patient, Parent or Guardian

Date

3/1/26

PATIENT ASSESSMENT FORM

Oral Health Information Adult	
Do you gag easily?	☒ Yes ☐ No
Do you wear dentures?	☒ Yes ☐ No
Does food catch between your teeth?	☒ Yes ☐ No
Do you have difficulty in chewing your food?	☒ Yes ☐ No
Do you chew on only one side of your mouth?	☒ Yes ☐ No
Do your gums bleed easily?	☒ Yes ☐ No
Do your gums bleed when you floss?	☒ Yes ☐ No
Do your gums feel swollen or tender?	☒ Yes ☐ No
Are your teeth sensitive?	☒ Yes ☐ No
Do you take fluoride supplements?	☒ Yes ☐ No
Do you prefer to save your teeth?	☒ Yes ☐ No
Do you want complete dental care?	☒ Yes ☐ No

Oral Health Information Pediatric/Child	
Does your child use a toothpaste with fluoride in it?	☐ Yes ☐ No
Do you help your child with toothbrushing?	☐ Yes ☐ No
Have your child experience in a dental treatment?	☐ Yes ☐ No
Have your child ever had cavities?	☐ Yes ☐ No
Does your child complain of mouth pain?	☐ Yes ☐ No
Does your child take a bottle to bed?	☐ Yes ☐ No
Does your child loves to eat foods like Chocolates, candy, snacks a lot?	☐ Yes ☐ No
Does your child gums bleed easily?	☐ Yes ☐ No

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

DENTAL CHARTING

UPPER

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

A B C D E F G H I J

LOWER

17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32

K L M N O P Q R S T

Category	0 = healthy	1 = changes	2 = unhealthy	Score
Lips	Smooth, Pink, Moist	Dry, chapped, red at corners, ulcerated or lump	Swelling or lump	
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 tissues, Little saliva present	No saliva present	
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

2

2

1

1

1

1

1

1

1

1

1

1

1

1

14

Total Points

Do you fallen in the pass years?

Are you using or advice to use cane or walker?

Are you lose a balance while walking?

You Worry about falling?

Do you use your arm/s to push your self from a chair?

Do you have trouble stepping up onto a crub/steps?

Are you sways when standing stationary?

Do you take short narrow step?

Are you stumble often or look at the ground when you walk?

Do you frequently have to rush to the toilet?

Do you have lost some feeling in one or both of your feet?

Do you take any medication to feel llight headed or sleepy?

YOUR FALL RISK

LOW

MODERATE

AT RISK

HIGH

URGENT

SEVERE

0

1

2

3

4

5

6

7

8+

Dr. Fatima Liagat

General Dentist

DENTISTREE DHA-57761808-001

DENTISTREE DENTAL CLINIC

Dentist Stamp :

Date : 03/01/26

United Arab Emirates

Al Mina Road, Jumeirah 1, Dubai

Next to Hyatt Place,

Shop 3, Wasi Port Views 8,