DENTISTREE DENTAL CLINIC

File no: 688

Name: Manas kumar		
Mobile no.: 0568311996	Email: manas2a92@gmail.com	
Date of Birth: 07/05/1989	Sex: ✓ M o F	Nationality: Indian
How do you know about us? o Family or Friends	o Internet	o Newspapers o Others

Medical History

Certain medical conditions can affect dental treatment and vice versa.

Please complete this form by answering the questions.

Chief Complaint: Teeth clean

All details will be strictly confidential.	Yes	No	Others, Please Specify
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?		✓	

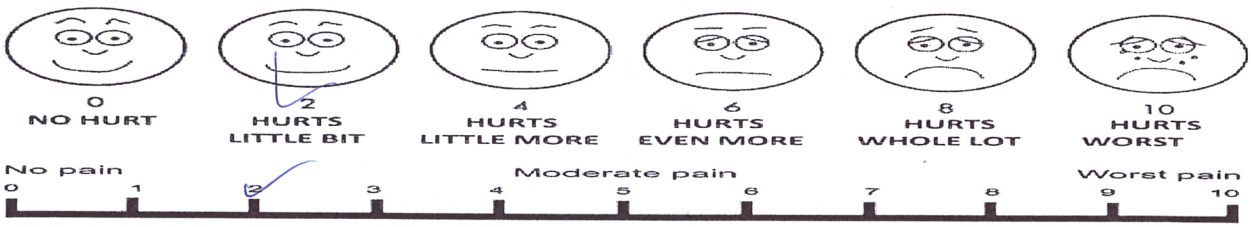
Do you have, or have you had any of the following

○ 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:	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)		✓	
Penicillin or other antibiotics		✓	
Asperin or Ibuprofen *	✓		
Reactions to metals		✓	
Latex or rubber dam		✓	
Foods		✓	

Additional questions for women.	Yes	No	Others, Please Specify
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.

D. Manas

Signature of Patient, Parent or Guardian

08/04/2022

Date