

Signature of Patient, Parent or Guardian

File no: 824

Mobile no.: 572 + 1886 30 Email: djanceliana@gnall.com Date of Birth: 28 or 196 Sext: 6 M o F Nationality: Indian How do you know about us? o Family or Friends of Internet o Newspapers o Others Medical History					
Mobile no.: 5.22 + 886.30 Email: djanceliana@gmail:Com Date of Birth: 2.5 Cut 96 Sex: OM of Newspapers of Others	Name: Ankita Salunkhe				
Date of Birth: 2.5 0.4 9.6 Sex: 8 M					
Medical History Certain medical conditions can affect dental treatment and vice versa. Please complete this form by answering the questions. Chief Complaint: 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 been hospitalized or had a major operation? 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 Heart Attack Asthma Heart Attack Epilepsy Leukemia Heart Disease Thyroid Problem Diabetes Thyroid Problem Diabetes Tuberculosis Hepatitis/laundice Stroke Arthritis Cancer AIDS/HIV infection Are you allergic, or have you reacted adversely to any of the following: Vers No Others, Please Specify Are you allergic, or have you reacted adversely to any of the following: Vers No Others, Please Specify Are you pregnant or trying to get pregnant? If yes, expected delivery date: 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.	Date of Birth: 2 8 0 1 2 C				
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