



DENTISTREE DENTAL CLINIC

File No:

474

Name: JAY KOTHADE

Mobile no.: 0553005929

Email: jayk2020@gmail.com

Date of Birth: 31/10/1972

Sex: ☒ M ☐ F

Nationality: INDIAN

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: _____

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

NA

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

Aspirin or Ibuprofen

Reactions to metals

Latex or rubber dam

Foods

Additional questions for women.

Yes

No

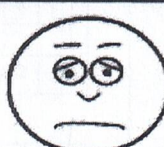
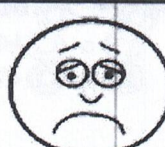
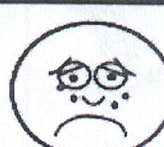
Others, Please Specify

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

0
NO HURT2
HURTS
LITTLE BIT4
HURTS
LITTLE MORE6
HURTS
EVEN MORE8
HURTS
WHOLE LOT10
HURTS
WORST

No Pain

Moderate Pain

Worst Pain

0 1 2 3 4 5 6 7 8 9 10

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.

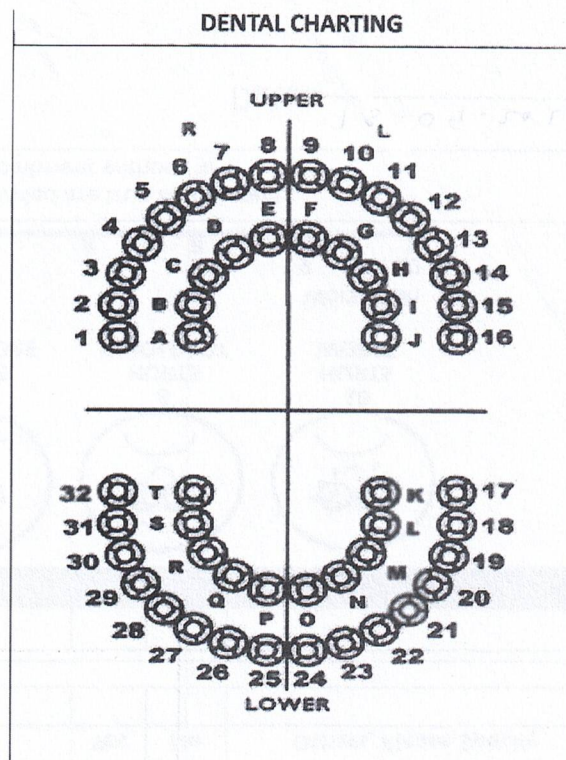
Signature: _____

Date: 18-09-2020

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

Oral Health Information Pediatric/Child	Yes	No
Does your child use a thoothpase with flouride in it?	<input type="checkbox"/>	<input type="checkbox"/>
Do you help your child with toothbrushing?	<input type="checkbox"/>	<input type="checkbox"/>
Have your child experince 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"/>

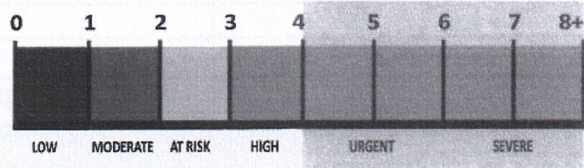


Category	0 = healthy	1 = changes	2 = unhealthy	Score
Lips	Smooth, Pink, Moist	Dry, chapped, red at corners	Swelling or lump ulcerated at corners	
Tongue	Normal, Moist, Pink	Patchy, fissured, red, coated	Patch that is red & ulcerated, swollen	
Gums & Tissues	Pink, Moist, Smooth	Dry, shiny, rough, swollen 1 to 6 teeth	Swollen, bleeding Generalized redness	
Saliva	Moist Tissues, Watery	Dry, sticky tissues, 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 type="checkbox"/>
Are you using or advice to use cane or walker?	2	<input type="checkbox"/>	<input type="checkbox"/>
Are you lose a balance while walking?	1	<input type="checkbox"/>	<input type="checkbox"/>
You Worry about falling?	1	<input type="checkbox"/>	<input type="checkbox"/>
Do you use your arm/s to push your self from a chair?	1	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble stepping up onto a crub/steps?	1	<input type="checkbox"/>	<input type="checkbox"/>
Are you sways when standing stationary?	1	<input type="checkbox"/>	<input type="checkbox"/>
Do you take short narrow step?	1	<input type="checkbox"/>	<input type="checkbox"/>
Are you stumble often or look at the ground when you walk?	1	<input type="checkbox"/>	<input type="checkbox"/>
Do you frequently have to rush to the toilet?	1	<input type="checkbox"/>	<input type="checkbox"/>
Do you have lost some feeling in one or both of your feet?	1	<input type="checkbox"/>	<input type="checkbox"/>
Do you take any medication to feel light headed or sleepy?	1	<input type="checkbox"/>	<input type="checkbox"/>
Total Points	14	<input type="checkbox"/>	<input type="checkbox"/>

YOUR FALL RISK →



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United Arab Emirates

Dr. Shyam Bhat
Specialist Oral & Maxillofacial Surgery
DENTISTREE DHA-00212475-007
DENTISTREE DENTAL CLINIC(BRANCH)



DENTISTREE DENTAL CLINIC




General Consent Form - Registration

Patient Name	:	Jay Kothari	Emirates ID	:	111-1111-1111111-1
File No	:	474	DOB	:	1973-10-31
Gender	:	Male	Nationality	:	Indian
Doctor's Name	:	Shyam Bhat	Date	:	2025-09-18

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 حقّي معرفة أسلوب وخطة العلاج الخاصة بي، كما أعلم أن المركز الطبي (العيادة) ليست مسنولة عن حاجياتي الخاصة بالأموال وأي متعلقات خاصة بي لم أقم بحفظها ، وأنا أخول المركز (العيادة) بإبلاغ أي معلومات عن علاجي إلى الهيئات الخاصة بتغطية نفقات العلاج ، أو الجهات الطبية التي قد تتولى تكملة علاجي فيما بعد ، وذلك إذا طلب منا ذلك. أقر بالموافقة على تسديد جميع نفقات علاجي بالمركز إما بالدفع الفوري أو بتحويل المركز (العيادة) بإرسال فاتورة علاجي إلى التأمين الصحي التي انتمي إليها ، كما اتعهد 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 Jay Kothari Date 2025-09-18	Date 2025-09-18	Dental Date 2025-09-18