# DENTISTREE DENTAL CLINIC

File No: 532

| | | | |
|---|---|---|---|
| Name: | MINI PURUSHOT | | |
| Mobile no.: | 0506546820 | Email: | minivk@gmail.com |
| Date of Birth: | 19.02.1962 | 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: Tooth cap chipped off.

| 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? | ✗ | ✓ | |

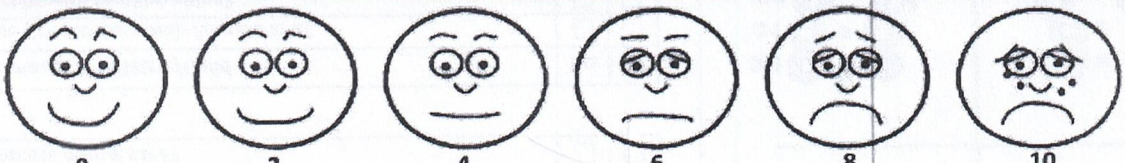
**Do you have, or have you had any of the following**

| | | | |
|---|---|---|---|
| ○ 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 | |

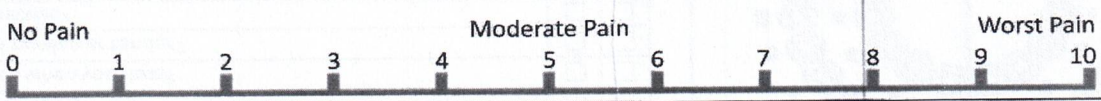
| Are you allergic, or have you reacted adversely to any of the following: | Yes | No | Others, Please Specify |
|---|---|---|---|
| Local anesthetics (Novocaine) | | ✓ | |
| Penicillin or other antibiotics | - | | Sulpha. |
| Asperin or Ibuprofen | | - | |
| Reactions to metals | | - | |
| Latex or rubber dam | | - | |
| Foods | ✓ | | gluten / lactose. |

| 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 | 2 | 4 | 6 | 8 | 10 |
|---|---|---|---|---|---|
| NO HURT | HURTS LITTLE BIT | HURTS LITTLE MORE | HURTS EVEN MORE | HURTS WHOLE LOT | HURTS WORST |



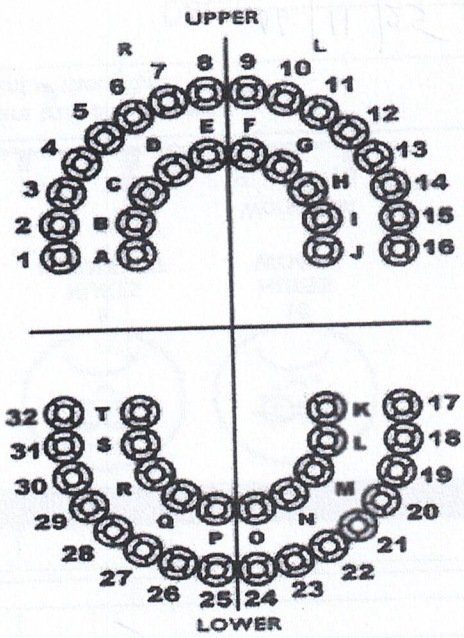

To the best of my knowledge, all of the preceding answer and information provided are true and correct.
If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Signature: ----------

Date: 06/11/25

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

## DENTAL CHARTING




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

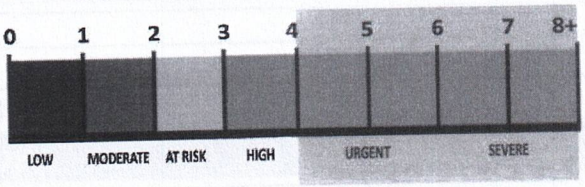
| Health Information for TMJ | Yes | No |
|---|---|---|
| Do you clench or grind your jaws frequently? | ☐ | ☐ |
| Do your jaws ever feel tired? | ☐ | ☐ |
| Does your jaw get stuck so that you can't open freely? | ☐ | ☐ |
| Does it hurt when you chew or open wide to take a bite? | ☐ | ☐ |
| Do you have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

| 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 | ☐ | ☐ |
| Are you using or advice to use cane or walker? | 2 | ☐ | ☐ |
| Are you lose a balance while walking? | 1 | ☐ | ☐ |
| You Worry about falling? | 1 | ☐ | ☐ |
| Do you use your arm/s to push your self from a chair? | 1 | ☐ | ☐ |
| Do you have trouble stepping up onto a crub/steps? | 1 | ☐ | ☐ |
| Are you sways when standing stationary? | 1 | ☐ | ☐ |
| Do you take short narrow step? | 1 | ☐ | ☐ |
| Are you stamble often or look at the ground when you walk? | 1 | ☐ | ☐ |
| Do you frequently have to rush to the toilet? | 1 | ☐ | ☐ |
| Do you have lost some feeling in one or both of your feet? | 1 | ☐ | ☐ |
| Do you take any medication to feel light headed or sleepy? | 1 | ☐ | ☐ |
| | 14 | ☐ | ☐ |
| Total Points | | | |

**YOUR FALL RISK →**

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United Arab Emirates

Dentist Stamp

Dr. Rutul Desai
General Dentist
DENTISTREE DHA-44339326-001
DENTISTREE DENTAL CLINIC(BRANCH

Date

# DENTISTREE DENTAL CLINIC

## General Consent Form - Registration

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Patient Name | : | MINI KESAVAN | | | | Emirates ID | : | 784-1962-3581313-4 |
| File No | : | 532 | DOB | : | 1962-02-19 | Nationality | : | Indian |
| Gender | : | Female | Doctor's Name | : | Rutul Desai | Date | : | 2025-11-06 |

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 sérvices 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.

اوافق أنا الموقع ادناه 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 اسلوب وخطة العلاج الخاصة بي،كما أعلم أن المركز الطبي ( العيادة ) ليست مسئولة عن حاجياتي الخاصة كالأموال وأي متعلقات خاصة بي لم اقم 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. اقر بالموافقة على تسديد جميع نفقات علاجي بالمركز إما بالدفع الفوري أو بتخويل المركز ( العيادة ) بإرسال فاتورة علاجي إلى التأمين الصحي التي انتمي اليها ، كما اتعهد بدفع أي مصاريف إضافية غير مغطاه من شركات التأمين ،هذا الإقرار سيتم حفظه في الملف الطبي الخاص بالمريض، اقر 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<br>MINI KESAVAN<br>Date<br>2025-11-06 | Date<br>2025-11-06 | Dental<br><br>Date<br>2025-11-06 |