

PART 1: Medical History & General terms and Conditions

Name:	ID#	:
Father / Husband Name:	Date	:

Age Years Sex: Male / Female (tick) Marital Status: Married / Single(tick)

Address: How would you like us to contact you? Kindly tick your choices City: State: Pin: Mobile Home Phone Do Not Call **Phone** Mobile 1 Mobile 2 To Contact Email DOB: **Profession Anniversary: Emergency contact name and number:**

Please answer each question:

When was the last time you saw your physician or a local doctor, and why?

1. Who is your family physician MBBS or a general doctor for general health?

Would you describe your health as: Excellent / Good / Fair / Poor (Kindly tick)		NameAddress						
3. Have you ever been hospitalized? 4. Have you ever fainted in dental Office 5. Do you have severe, frequent. Or migraine headaches? 6. Are you nervous about dental treatment? 7		Phone						
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Dialysis? 25 Do you have history of suffering from tuberculosis (TB) in any form 26 Are you allergic or have you had adverse reaction to anaesthetic, antibiotic 27 Or other drug? If yes list and describe all medicines or agents								
25 Do you have history of suffering from tuberculosis (TB) in any form Yes No 26 Are you allergic or have you had adverse reaction to anaesthetic, antibiotic Or other drug? If yes list and describe all medicines or agents								
26 Are you allergic or have you had adverse reaction to anaesthetic, antibiotic Yes No	25		from tuberculosis (TB) in	anv form				
Or other drug? If yes list and describe all medicines or agents								
		Or other drug? If yes list and describe all medicines or agents.						

Please turn over

- 27 Are you on any special diet?
- 28 If female, is there a possibility that you are pregnant?
- 29 Please list all medications and dose you take including aspirin, ecosprin, birth control pills etc Including steroids or homeopathy.
- 30 Describe any other medical conditions that have not been mentioned above.

General Terms and Conditions

Place:

- 1. The information provided above will be kept confidential.
- 2. Please ask about anything you do not fully understand or wish to have explained in more detail.
- 3. At any stage during or before the treatment, the doctor can refer you or get in touch with your physician regarding written consent / opinion on your present illness.

Yes

Yes

No

No

- 4. You will be given an opportunity to discuss your dental procedure(s) including the risk involved and consequences of no treatment at all, in detail with the doctor.
- 5. If deemed necessary, specific informed consent would be obtained from you for specialised procedures only.
- 6. Your records, including the radiographs and photographs are the belongings of this clinic and the copies of the same if required, could be obtained on authorization at additional cost.
- 7. Perfect results for any procedure are not guaranteed or warranted.
- 8. Rescheduling of appointments should be preferably carried out at least 24 hour before.
- 9. Full fee for the procedure(s)is payable before the commencement of the treatment.

By signing below, I do hereby declare that I have carefully read and agree to the general terms and conditions. I have also provided the information regarding my medical history to best of my knowledge and not concealed any facts. I also agree that I will voluntarily bring to the knowledge of the doctor any change in my medical status.

Date:						
Place:	Signature: Patient or Parents (in case of minor)					
	PART 2: Informed Consent					
Impoi	rtant Note: Kindly provide informed consent by signing below only after your examination, counselling and meeting with the doctor					
1.	I provide my consent to the Doctor(s) to carry out any routine dental diagnostic or therapeutic treatment procedures required to treat may condition(s).					
2.	The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of procedure to be					
	in the language that I best understand and also agree that perfect results for any procedures are not guaranteed or warranted.					
3.	I have been informed, the possible alternative methods of treatment including no treatment at all in the language that I best understand.					
4.	I have been informed of the amount of the full fee of the procedure(s) payable by me towards my treatment and agree to pay before the commencement of the treatment.					
5.	The doctor has explained to me in detail that there is certain inherent and potential risk(s) in any treatment plan or procedure(s)					
	including the one associated with the use of local anaesthesia.					
6.	I have been given an adequate opportunity to question the doctor concerning the nature of treatment, inherent risk(s) of the treatment, and the alternatives to the treatment.					
7.	This consent form does not include the entire scope of comprehensive discussion; that I had regarding the proposed treatment					
	with doctor in detail.					
8.	In consideration to the above I authorize and provide the consent to the Doctor(s), and any other agents or employees of					
	Gandhis Dental Care, and such assistant(s) as may be selected by them to treat me to best of their ability.					
Date:						

Signature: Patient or Parents (in case of minor)