**Dr. Divya Dayal's Dental Clinic™** **Health History and Consent Form**

**Name:**________________________________________________

**Address:** ______________________________________________

_________________________________________________________

**Age:**____ **Date:**________ **Mob:** __________________________

**Gender: Male/Female** **Occupation:** ______________________

**Medical History** **Date of Last Visit:**__________________

**Physicians Name:**_______________________________________

1. Are you currently under medical treatment? **Yes/No**
2. Have you ever had any serious illness/operation? **Yes/No**
3. Are you currently taking any medication? **Yes/No**
4. If yes, name medications: ______________________________

   _____________________________________________________

5. Do you take alcohol, cocaine, smoke, tobacco? **(Please Circle)**
6. Do you have any allergies: ______________________________

   _____________________________________________________

7. Are you **a)** Pregnant **b)** Nursing **C)** Taking Birth Control Pills

**Chief Complaint:** ________________________

_______________________________________

_______________________________________

- ☐ Dental Exam and Cleaning
- ☐ Bleeding Gums
- ☐ Dentures
- ☐ Root Canal Treatment
- ☐ Loose Teeth or Broken
- ☐ Fillings
- ☐ Tooth Extraction
- ☐ Tooth Pain
- ☐ Sensitivity to Heat or Cold
- ☐ Grinding Teeth

**Please Check All That Apply:**

- Aids
- Anemia
- Arthritis
- Artificial Heart Valves

- Bleeding Abnormally
- Blood Disease
- Cancer
- Chemotherapy

- Diabetes
- Epilepsy
- Heart Problems
- Hepatitis B

- Herpes
- High BP
- HIV Positive
- Jaundice
- Stroke

- Thyroid
- Tuberculosis
- Ulcer
- Venereal Disease
- Others_____________________

**Patients Statement: I give my consent and authorize Doctors and Staff at Dr. Divya Dayal's Dental Clinic to:**

- Provide dental diagnostic treatment and surgical procedures for myself/son/daughter/wife/husband as advised by Specialist(s) under prudent dental practice.
- Undertake any additional, emergency or other treatment procedures as they deem fit, if during the course of treatment any unforeseen conditions are discovered or unusual conditions develop.
- The use of anesthesia: surface/ infiltrative / block / local / general / conscious sedation if indicated.
- Disposal of the tooth / teeth / tissue and their removal from the oral cavity at the discretion of the doctor.
- Photographing or televising of the operational procedures for medical, scientific or educational purposes provided my identity is not revealed.

The nature and purpose of the treatment to be rendered, the possible hazards involved and the alternative method of treatment have been fully explained to me and I have freely asked for the explanation of the treatment and am convinced of the same.

I certify that the statements made in the above consent form have been read over by me. I have fully understood the implications of the above.

On the basis of the above statements, I request to have the procedure.

**Name of the Patient:** **Name of Witness:**

**Signature:** **Signature:**