

CHAGGER DENTAL PATIENT INFORMATION

Submitted: 2026-05-18 02:02 AM

PATIENT PROFILE

Title	<input checked="" type="radio"/> Mr. <input type="radio"/> Ms. <input type="radio"/> Mrs.	Full Name	<u>Vikash Kumar</u>
Age	<u>22</u>	Sex	<input checked="" type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Others
Marital Status	<input type="radio"/> Single <input checked="" type="radio"/> Married <input type="radio"/> Prefer Not to Say	Date of Birth	<u>2026-05-01</u>
Street Address	<u>1155 North Service Rd W Suite 11</u>		
City	<u>Oakville ON</u>	Province / State	<u>Oakville</u>
Postal Code	<u>L6M 3E3</u>		
Email Address	<u>vikash@tastechnologies.com</u>		
Home Phone	<u></u>	Cell Phone	<u>416-578-0907</u>
Occupation	<u></u>	Employed By	<u></u>

DENTAL INSURANCE & CARE PROVIDERS

Dental Insurance?	<input type="radio"/> Yes <input type="radio"/> No	Company	<u></u>
Policy No.	<u></u>	ID / Cert No.	<u></u>
Family Physician	<u></u>	Physician Phone	<u></u>
Previous Dentist	<u></u>	Previous Dentist Phone	<u></u>
Referral Credit	<u></u>		

EMERGENCY CONTACT

Contact Name	<u></u>	Relationship	<u></u>
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Address _____

Phone Number _____

CONFIDENTIAL MEDICAL HISTORY

1. Date of last complete physical examination _____

2. Are you currently under a physician's care?

Yes No

Specify _____

3. Do you have frequent headaches?

Yes No

4. Do you smoke?

Yes No

5. Do you drink alcohol?

Yes No

Specify _____

6. Do you do recreational drugs?

Yes No

7. Do you routinely take vitamins, herbal substances, or natural products?

Yes No

Specify _____

8. Are you taking any medications?

Yes No

Specify _____

9. Have you taken any prolonged medication in the past?

Yes No

Specify _____

10. Have you taken cortisone or steroids?

Yes No

11. Have you ever been hospitalized for any surgery?

Yes No

Specify _____

12. Are your ankles often swollen?

Yes No

13. Have you gained or lost excessive weight recently?

Yes No

14. Are you pregnant?

Yes No

Specify _____

15. Sensitive / adverse reactions

Latex

Penicillin

Metals

Sulfa Drugs

16. Allergies / adverse reactions _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic (Freezing) | <input type="checkbox"/> Barbiturates (Sleeping pills) |
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Codeine | |

17. Allergic or adverse reactions to any other drugs?

Yes **No**
Specify _____

18. Treated for or told you have any of the following

- | | | |
|---|--|--|
| <input type="checkbox"/> COVID-19 | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV (AIDS) |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Hypertension / Low BP | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Mental Disability |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes Type I / Type II | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Venereal Disease | | |

19. Have you ever experienced heavy bleeding?

Yes **No**

20. Is there anything else we should know?

Yes **No**
Specify _____

21. Have you been diagnosed with any other disease, condition or problem?

Yes **No**

22. Is there anything about your health we should be aware of?

Yes **No**
Specify _____

23. Do you wish to speak to the doctor privately?

Yes **No**

CONFIDENTIAL DENTAL HISTORY

24. Date of last complete exam _____

25. Date of last cleaning _____

26. Date of last x-rays _____

27. Did you see your last dentist regularly?

Yes **No**

28. How often did you see your last dentist?

Specify _____

29. Have you ever been advised to take antibiotics?

Yes **No**

30. Heavy bleeding following extractions? Yes No

31. Have you ever had gum treatment or surgery? Yes No

32. Have you had any orthodontic treatment? Yes No

33. Have you ever had an unpleasant dental experience? Yes No

34. How can we make your dental experience more pleasant? _____

35. Is there anything else we should know? _____

36. What brings you to the office today? _____

37. Are you in any discomfort? Yes No
Specify _____

38. Do you have or have you experienced

- | | | |
|--|--|--|
| <input type="checkbox"/> Tooth sensitivity | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Ear ache |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Sore gums |
| <input type="checkbox"/> Gagging | <input type="checkbox"/> Missing teeth | <input type="checkbox"/> Loose Teeth |
| <input type="checkbox"/> Spaced or Crooked teeth | <input type="checkbox"/> Unexplained nosebleed | <input type="checkbox"/> Unsatisfactory dentures |
| <input type="checkbox"/> Difficulty opening or closing | <input type="checkbox"/> Lump or swelling in your mouth | <input type="checkbox"/> Clench or Grind |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Popping or clicking in the jaw joints | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Venereal Disease | | |

39. Does food get caught between your teeth? Yes No

40. Do you have any sore spots in your mouth? Yes No

41. Have you had any teeth replaced? Yes No

42. Interested in permanent tooth replacement? Yes No

43. Have you ever been given local anesthesia? Yes No

44. Have you ever been given general anesthesia? Yes No

45. Are you satisfied with the appearance of your teeth? Yes No

46. Are you anxious to keep your natural teeth? Yes No

47. Are you tense during dental visits? Yes No

48. Interested in a method to calm your nerves? Yes No

49. How can we help you today?

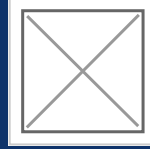
sdsd sdsds

Patient Consent

Verified & Authorized Digital Copy

- I agree to the privacy policy regarding medical records.
- I consent to receiving emails and newsletters.

SIGNATURE



PRINT NAME

Vikash Kumar



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