chaggerdental

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CHAGGER DENTAL PATIENT INFORMATION

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PATIENT PROFILE

Title	○ Mr. ○ Ms. ○ Mrs.	Full Name	**Vikash Kumar**
Age	**22**	Sex	● Male ○ Female ○ Others
Marital Status	● Single ○ Married ○ Prefer Not to Say	Date of Birth	**2026-05-08**
Street Address	**1155 North Service Rd W Suite 11**		
City	**Oakville ON**	Province / State	**Oakville**
Postal Code	**L6M 3E3**		
Email Address	**vikash@tastechnologies.com**		
Home Phone		Cell Phone	**416-578-0907**
Occupation		Employed By	

DENTAL INSURANCE & CARE PROVIDERS

Dental Insurance?	○ Yes ○ No	Company	
Policy No.		ID / Cert No.	
Family Physician		Physician Phone	
Previous Dentist		Previous Dentist Phone	
Referral Credit			

EMERGENCY CONTACT

Contact Name		Relationship	

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

- [ ] Aspirin
- [ ] Local Anesthetic (Freezing)
- [ ] Barbiturates (Sleeping pills)
- [ ] Nitrous Oxide
- [ ] Codeine

17. Allergic or adverse reactions to any other drugs? ◯ **Yes** ◯ **No**

Specify _____

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

- [ ] COVID-19
- [ ] Heart Murmur
- [ ] Arthritis
- [ ] Hepatitis B
- [ ] Asthma
- [ ] HIV (AIDS)
- [ ] Blood Disorder
- [ ] Hypertension / Low BP
- [ ] Anemia
- [ ] Liver Disease
- [ ] Leukemia
- [ ] Mental Disability
- [ ] Cardiovascular Disease
- [ ] Renal Disease
- [ ] Cancer
- [ ] Rheumatic Fever
- [ ] Diabetes Type I / Type II
- [ ] Thyroid Disease
- [ ] Emphysema
- [ ] Tuberculosis
- [ ] Epilepsy
- [ ] 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

- ☐ Tooth sensitivity
- ☐ Bad breath
- ☐ Ear ache
- ☐ Headaches
- ☐ Bleeding gums
- ☐ Sore gums
- ☐ Gagging
- ☐ Missing teeth
- ☐ Loose Teeth
- ☐ Spaced or Crooked teeth
- ☐ Unexplained nosebleed
- ☐ Unsatisfactory dentures
- ☐ Difficulty opening or closing
- ☐ Lump or swelling in your mouth
- ☐ Clench or Grind
- ☐ Neck pain
- ☐ Popping or clicking in the jaw joints
- ☐ Thyroid Disease
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Epilepsy
- ☐ 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?

qwqwq

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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