chaggerdental

Oakville
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905-257-2221

CHAGGER DENTAL PATIENT INFORMATION

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PATIENT PROFILE

Title	● Mr. ○ Ms. ○ Mrs.	Full Name	Vikash Kumar
Age	38	Sex	● Male ○ Female ○ Others
Marital Status	○ Single ● Married ○ Prefer Not to Say	Date of Birth	2026-05-31
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	416-578-0907	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	416-578-0907
Previous Dentist		Previous Dentist Phone	416-578-0907
Referral Credit			

EMERGENCY CONTACT

Contact Name		Relationship	

Address _____ Phone Number 416-578-0907

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?

Just for testing purpose, please ignore it.

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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