



**DOCTOR
PREETY
DESAI**
INC.

Certified Specialist
BSc, DDS, Dip Periodontics, FBCCD
Periodontics, Implant Surgery
502-275 Lansdowne Street
Kamloops, BC, V2C 1X8
PH 250-851-2570, FAX 250-851-9929

PERSONAL INFORMATION:

Name First, Middle, Last		Sex	DOB (D/M/Y)	Marital Status
Home Address (Street, City, Postal Code)			MSP#	
Home Phone	Bus Phone	Bus Address	Cell Phone/Pager	
Employer (Self)		Occupation		
Employer (Spouse)		Family Dentist	Referred By	
Person Responsible for Payment of Account		Relation	Phone	
Emergency Contact		Emergency Phone #		

DENTAL INSURANCE:

Primary Insurance Co	Policy/Group #	ID or Cert #	SIN#
Secondary Insurance Co	Policy/Group #	ID or Cert #	SIN#
Secondary Plan Holder's DOB (D/M/Y)			

MEDICAL INFORMATION:

Family Doctor	Last Physical Examination (D/M/Y)	Results
1. Are You Being Treated Now by Your Family Doctor? Yes	No	For What Reason?
2. What Prescription or Non Prescription Medications are you taking?		
3. Are you sensitive or allergic to any medications or non-medications?		
4. Have you had any hospitalizations? For What? Dates?		
5. Have you had any blood transfusions? Dates? For What?		
6. Have you had or are being treated for any of the following:		

- | | | |
|--|-------------------------------------|--|
| yes [] no [] HIV Positive | yes [] no [] Stroke | yes [] no [] Nervousness |
| yes [] no [] AIDS | yes [] no [] Anemia | yes [] no [] Epilepsy or Seizures |
| yes [] no [] Asthma | yes [] no [] Allergies or Hives | yes [] no [] Fainting or Dizzy Spells |
| yes [] no [] Hay Fever | yes [] no [] Ulcers | yes [] no [] Pacemaker |
| yes [] no [] Tuberculosis | yes [] no [] Arthritis | yes [] no [] Thyroid Disease/Goiter |
| yes [] no [] Rheumatic/Scarlet Fever | yes [] no [] Venereal Disease | yes [] no [] Radiation/Cobalt Therapy |
| yes [] no [] Heart Murmur | yes [] no [] Kidney Disease | yes [] no [] Psychiatric Therapy |
| yes [] no [] Heart Disease/Angina | yes [] no [] Bladder Disease | yes [] no [] Chemotherapy |
| yes [] no [] Hepatitis A/B/C | yes [] no [] Gall Bladder Disease | yes [] no [] Osteoporosis |
| yes [] no [] High Blood Pressure | yes [] no [] Diabetes | yes [] no [] Problems with Anaesthesia |
| yes [] no [] Glaucoma | yes [] no [] Artificial Joints | yes [] no [] Bleeding Problems |

yes [] no [] Family History of Any of the Above? Which Ones?

Further explanations of above conditions:

6. Do you smoke? For how many years? How many cigarettes/day?
8. Do you experience chest pain on exertion?
9. Do you have shortness of breath upon exercising?
10. Do your ankles swell or do you bruise easily?
11. Have you ever had yellow jaundice?
12. Do you urinate (pass water) more than 6 times a day?
13. Are you thirsty much of the time?
14. Does your mouth become dry?
15. Have you lost or gained weight (more than 10 pounds) in the past year?

TURN OVER



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MEDICAL INFORMATION CONTINUED.....

- 16. Are you following a diet? _____
- 17. Do you have cataracts or glaucoma? _____
- 18. Do you have any difficulty swallowing? _____
- 19. Has a doctor ever said you have cancer or a tumour? _____
- 20. Have you had excessive bleeding from a cut or a wound? _____
- 21. Do you experience frequent or severe headaches or migraines? _____
- 22. Are you under abnormal stress? (ie. Marital, social, business, family death) _____
- 23. Do you sometimes take medicine to relieve nervousness or stress? _____

FEMALES (males go to #29):

- 24. Are you pregnant? _____ Date of Delivery? _____
- 25. Are you taking the birth control pill? _____
- 26. Are you pre- or post menstrual? _____
- 27. Are you post menopausal? _____ Are you taking estrogen supplements? _____ Dosage: _____
- 28. Have you had problems with early or late delivery of any of your children? _____ Any C-Sections? _____

DENTAL INFORMATION:

- 29. Have you had any serious trouble associated with any previous dental treatment? _____
 Explanation? _____
- 30. Have you bled excessively in the past after tooth extraction? _____
- 31. Have you had any recent dental x-rays? When? _____
- 32. Have you had problems with local or general anaesthesia? _____
- 33. Do you clench or grind your teeth? _____
- 34. Are any of your teeth sensitive to hot, cold or sweets? Where? _____
- 35. Are you happy with the appearance/look of your teeth and smile line? _____
- 36. Have you had excessive swelling or pain after oral surgery? _____
- 37. Have your teeth been recently cleaned? When? _____
- 38. Do you have bleeding gums? _____
- 39. Do you have a bad taste in your mouth? _____
- 40. Does food pack in between your teeth? _____
- 41. Have you had treatment for periodontal disease before? _____
- 42. Are you willing to become actively involved in the treatment of any of your teeth and gums? _____
- 43. What is your understanding of why you are referred to Dr. Desai? _____
- 44. Briefly state your feelings towards dentures: _____
- 45. What is your chief complaint concerning your teeth or mouth? _____
- 46. Have you had pain, gum boils, swellings in your mouth? _____
- 47. Do you experience cold sores or fever blisters in your mouth, lips or gums? _____
- 48. Do you have any loose teeth? _____
- 49. Have your teeth separated lately, creating spaces? _____
- 50. Based on what your dentist has told you and what you know about your mouth, please rate the condition of your mouth on a scale of 1 - 10 (where 1 is severe disease and tooth loss is anticipated and 10 is optimal health). 1 2 3 4 5 6 7 8 9 10

TO THE BEST OF MY KNOWLEDGE ALL OF THE ABOVE ANSWERS ARE TRUE AND CORRECT, IF I HAVE ANY CHANGES IN MY HEALTH, I WILL INFORM DR. DESAI AND HER STAFF AT MY NEXT APPOINTMENT. I ALSO UNDERSTAND THAT THE COSTS ENTAILED IN TODAY'S CONSULTATION ALONG WITH X-RAYS NECESSARY WILL BE PAID ON THE SAME DAY.

SIGNATURE OF PATIENT _____

PRINTED NAME _____

DATE _____