CARE n CURE DENTAL

**Dr.Tejal Thorve**
BDS (Mumbai), PGDMLS

4, Om Trimurti Sty,Jijainagar,Dombivli East

# PATIENT REGISTRATION FORM

## Welcome to our practice

Although the dentist primarily treats the area in and around your mouth, your mouth is a part of your body. Health problems you may have or medicines you take could have important interrelationship with the treatment that you may receive.
If you have any difficulty in filling up this form, please let us know….we will be happy to help you ☺

**Personal Details** **(FILL IN CAPITAL LETTERS)**

Name: _____

Date of Birth : _____ Male/Female

Mobile Number: | | | | | | | | | | | Email ID:_____

Address: Room no:_____ Bldg name : _____

Locality/ Area _____ City: _____

**Family Doctor's Name**_____ _____

Are you experiencing/have you experienced any of the following? (Tick Mark if Yes)

| | | |
|---|---|---|
| ☐ Heart Problems | ☐ Arthritis | ☐ Liver Disease |
| ☐ High Blood Pressure | ☐ HIV/AIDS | ☐ Kidney Problems |
| ☐ Low Blood Pressure | ☐ Epilepsy | ☐ TB |
| ☐ Diabetes | ☐ Hepatitis / Jaundice | ☐ Chronic Headaches |
| ☐ Thyroid Problems | ☐ Blood Disease | ☐ Dental treatment |
| ☐ Asthama | ☐ Radiation Treatment | _____ |
| ☐ Acidity | | _____ |

**List the medicines you are currently taking:**

_____

_____

**Are you allergic to any of the following – (**please tick)

☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Iodine ☐ Local Anaesthetic ☐ Ibuprofen

Any Other_____

**WOMAN**-

Are you Pregnant? ☐ Yes ☐ No

Are you breastfeeding a child? ☐ Yes ☐ No

**HABITS**- (please tick) Occasional / Regular

☐ Pan Masala ☐ Tobacco ☐ Gutkha ☐ Meshri ☐ Smoking ☐ Alcohol

*** I hereby declare that the information provided above is true and correct to the best of my knowledge ***

**Signature** _____ **Date** _____

**Name of parent/guardian**_____**Ref by-**_____