OP No :
Date :

S.J. DENTALCARE
Multi Speciality Dental Clinic
Laser and Implant Centre

Dr. BHANU PRAKASH, BDS
Regd. No. A8102
Cell : 9848226612, Clinic : 0891-2502189
E-mail: morthabhanuprakash60@gmail.com

D.No. 54-17/132, Opp. SBI, Bhanu Nagar, H.B. Colony, Krishna College Road, Visakhapatnam-530022.

Timings : 9-00 am to 1-00 pm; Sunday: 4-00 pm to 9-00 pm

CASE SHEET

Name :
Occupation :
Mobile No. :
Person to contact & Mobile No. :

Age / Sex :
Address :
Email ID :
Blood Group (if Known) :

Reference (Refered by) :

The following questionnaire will be used by your dentist to treat you safely.
Please answer all questions as correct as possible.

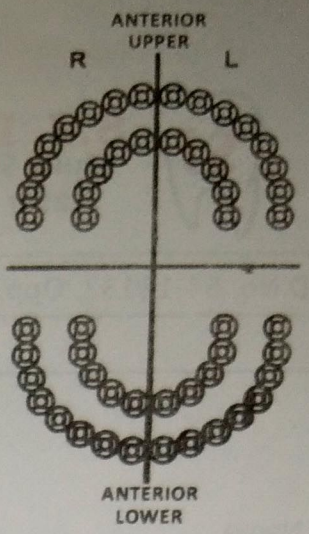
Do you have a history of any of the following ailments / Health Issues
Any related diseases to:

Disease / Condition	Yes	No	Disease / Condition	Yes	No	Condition / Others	Yes	No
Cardiovascular			Hepatic / Liver			Smoking		
Respiratory			Renal / Kidney			Alcohol		
Gastro Intestinal			Endocrine / Thyroid			Chewing Habit		
Diabetes			Neural			Any Hospitalized / Operated Condition		
Blood Pressure			Epilepsy / Fits					
Asthma			Allergitic to Any drugs			Dental history		
Any Medication Aspirin Ecosprin Clopitab / Others						Any other Health Issues		
			Pregnant					
			Any Abnormal Bleeding					
			Aids / HIV / Hepatitis B					

Do you have (or) ever had any of the following Intra-oral / Extra-oral / Soft Tissue / Hard Tissue Condition

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Tooth Pain			Discoloured			Swelling		
Sensitive Teeth			Dental Caries			Lymphnode Enlargment		
Missing Teeth			Fractured			Any Neural Problems		
Loosening of Teeth			Fixed Partial Denture			Trigeminal Neuralgia		
Bleeding Gums			Removable Partial Denture			Bells Palsy		
Bad Breath			Complete Denture			Trismus		
Calculus / Tartar			Implant					
Stains			Ortho Braces					

Chief Compliant :



Radiological Examination :

Final Diagnosis :

Treatment Plan :

IF YOU COULD CHANGE YOUR SMILE WHAT COULD BE YOUR CHANGE / OTHERS

Condition	Yes	No	Condition	Yes	No
Replacement of missing teeth			Close gap between the teeths		
Straighten teeth			Teeth alignment		
Change of Teeth shape			Jaws Pains / Dislocation		
Teeth Whitening			Bad Breath		
Smile designing			Teeth Fillings		
Gummy Smile Correction			Teeth Cleaning		

AUTHORISATION FOR TREATMENT / CONSENT FORM

I, authorize the **S.J. DENTALCARE** doctors to perform the Root Canal Treatment / Crown and Bridge Prosthesis / Extraction / Implant and Administer Anesthesia.

- I understand the practice of medicine is not an exact science. I acknowledge that no guarantee can be made regarding the results of the procedure. However I have been communicated the intended benefits and outcome of the procedures as:

  RCT - Save tooth and restore function without Extraction
  Crown & Bridge - it simulates the function of a natural permanent tooth / teeth
  Extraction - extraction or removal of my tooth / teeth since the same could not be saved.

- My Doctor/Dentist has explained the procedure necessary to treat my condition and understand the same.

- I consent to administration of local anesthesia considered necessary of indicated in the judgement of the treating Doctor/Dentist

- **Local anesthesia** includes Novocain, Lidocaine, Lignocaine / Others to block pain pathways in a localized area by injection i understood these are risks involved with anesthesia and oral sedation I understood that i must have responsible adult transport me to the office / Dental Clinic and home afterward.

- My doctor has explained to me the risk and complications. I understand all operations and procedures have an extremely rare risk of death. Doctor has clarified that these are only the common risks and serious risks that are documented here:

  RCT - Breakage of instrument in the canal,perforations of the canal with instruments, blocked root canals that cannot be ideally cleaned, post-operative infection, Tooth fracture that requires extraction, complication related to anesthesia. Crown & Bridge Prosthesis - Reduction of adjacent tooth structure to replace missing tooth, Sensitivity of the teeth, Crowned or bridges abutment teeth (supporting teeth) may require root canal treatment. Extraction- Prolonged Bleeding, Swelling, bruising, delayed healing, secondary infection, Nerve Injury, Trismus, Breakage of teeth or teeth coming out in fragments

- **Drug & Medication:** I understood that antibiotics and analagesics and other medication can cause allergic Reactions causing redness and swelling of the tissues, pain itching, Vommting and anaphylactic shock.

- I accept full responsibility of all risks related to the use of this medicine during the course of treatment.

- Doctor has explained the alternatives for the procedure as -

  RCT - Extraction foiiowed by Removable/fixed partial denture or an Implant Crown & Bridge Prosthesis- Removable partial denture or an Implant

- In case of Extraction doctor has explained the removed tooth could be replaced by Removable I fixed partial denture, complete denture or an Implant in case the functionality is intended to be restored, also he has explained me that the same may not be required in case of the third molars / Wisdom Teeth.

- It has been explained to me by the doctor that, during the course of the operation unforeseen condition may be revealed that may necessitate an extension of original procedure therefore I authorize and request the Doctor/ Dentist, his assistant or his designates to perform such surgical procedure(s) as necessitated and deemed mandatory and advisable in the interest of patient safety.

- I agree to undergo any blood or blood product transfusion if it is as required during the procedure as determined by the attending surgeon & anesthetist

- I understand the details of the procedure and in case of any unspecified complication during or subsequent to treatment will not hold the treating doctor or hospital authority responsible

- **Fees :** I understand that an estimate of fees for the above dental case will be provided upon request and that i am encouraged to discuss all fees related to the case before services being rendered.

- I assume financial responsibility for all fees and provide payment by cash, credit card, debit card, demand draft, paytm, online transfer, cheque before the start of the treatment.

- All of my questions have been fully and clearly answered to my satisfaction in the language. I understand and I believe that Ihave adequate Knowledge on which to base an informed consent to the proposed treatment/procedure.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTOOD THE ABOVE MENTIONED CONSENT THAT THE EXPLANATION THERE IN REFERRED TO WERE MADE, THAT ALL BLANKs / STATEMENT REQUIRING COMPLETION WERE FILLED IN.

I affirm that the above information is accurate to the best of my knowledge and authorize the dental staff to perform any dental service that I may need. The dental staff is not responsible to for any errors that occur as a result of this form being incorrectly filled out.

నా యొక్క అనుమతితోనే రోగ నిర్ధారణ పరీక్షలు, దంతవైద్యము, ముఖ మరియు దవడ, నోటి సంబంధమైన శస్త్ర చికిత్సలు చేయించుకొనుటకు అంగీకరించుచున్నాను. చికిత్సలకు అవసరమైన మత్తుమందు ఇచ్చుటకు కూడా నా అంగీకారము తెలుపుచున్నాను. పరీక్షలు మరియు చికిత్స చేసేటప్పుడు ఎదురుకాబోయే ఇబ్బందులు వివరించి యున్నారు. ఇందుకు నా పూర్తి అంగీకారము తెలపుచున్నాను.

Patient (or) Guardian Signature / Thumb Impression

Date :

Treatment Fee Estimation

Mode of payment : ☐ Cash ☐ Debit Card ☐ Credit Card ☐ Online Transfer ☐ Cheque / DD

Date	Clinical Notes	Amount	
		Paid	Due