Sri Shankara Dental Clinic

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Dr. Advaitha Anand — BDS, MDS (Conservative Dentistry & Endodontics)
Mon–Fri 9:30am–12:30pm & 4:00pm–7:00pm · Sat 9:30am–12:30pm · Sun closed
Clinical Establishment Regn. No.: _____ · GSTIN (if applicable): _____

PATIENT REGISTRATION FORM

Please complete all sections in block letters. Your information is confidential and is collected, used and stored in accordance with the Digital Personal Data Protection Act, 2023.

1 REGISTRATION DETAILS

OPD / Registration No. _____ Date ____/____/_____

Referred by

☐ Doctor _____ ☐ Existing patient _____ ☐ Online / Google ☐ Social media ☐ Insurance / TPA panel
☐ Walk-in ☐ Other _____

2 PATIENT DETAILS

Full name

Father's / Husband's name

Date of birth ____/____/_____ OR Age _____ years

Gender ☐ Male ☐ Female ☐ Other

Marital status ☐ Single ☐ Married ☐ Other

Blood group _____ Occupation _____

Preferred language ☐ Hindi ☐ English ☐ Other _____

Current address

City _____ State _____ PIN _____

Permanent address (if different)

Mobile _____ Alternate mobile _____

Is your mobile number on WhatsApp? ☐ Yes ☐ No

Email

Preferred way to contact you ☐ Call ☐ SMS ☐ WhatsApp ☐ Email

3 HEALTH ID, SCHEMES & INSURANCE

ABHA number / ABHA address

Aadhaar number (optional — you are not required to provide this; it is used only if you wish to link an ABHA or claim a government scheme)

Government schemes — tick if applicable and note the card number

☐ Ayushman Bharat PM-JAY _____ ☐ CGHS _____ ☐ ECHS _____
☐ ESIC _____ ☐ State scheme _____

Health insurance / corporate panel

Insurer / TPA _____ Policy no. _____

Employer / corporate panel _____ Employee ID _____

Are you seeking cashless treatment? ☐ Yes ☐ No

Cashless treatment requires pre-authorisation from your insurer or TPA and is subject to their approval.

4 PERSON RESPONSIBLE / GUARDIAN

Complete if the patient is under 18 years or is unable to give consent themselves.

Name _____ Relationship to patient _____

Mobile _____ Address (if different) _____

5 EMERGENCY CONTACT

Name _____ Relationship _____

Mobile _____ Alternate number _____

Family doctor / physician _____ Phone _____

6 MEDICAL HISTORY

Your general health affects dental treatment. Please answer every question carefully.

Do you have, or have you ever had, any of the following?

Condition	Y	N	Condition	Y	N
Heart disease / chest pain	☐	☐	Diabetes (sugar)	☐	☐
Heart attack (year: ____)	☐	☐	Thyroid problem	☐	☐
Heart murmur / valve problem	☐	☐	Epilepsy / fits	☐	☐
Artificial heart valve	☐	☐	Asthma / breathing problem	☐	☐
Rheumatic fever	☐	☐	Tuberculosis (TB)	☐	☐
Pacemaker	☐	☐	Kidney disease / dialysis	☐	☐
High BP	☐	☐	Liver disease	☐	☐
Low BP	☐	☐	Jaundice / Hepatitis B or C	☐	☐
Paralysis / stroke (year: ____)	☐	☐	HIV	☐	☐
Anaemia / low haemoglobin	☐	☐	Cancer (type: _____)	☐	☐
Bleeding that does not stop	☐	☐	Radiotherapy to head or neck	☐	☐
Thalassaemia / sickle cell	☐	☐	Chemotherapy	☐	☐
Weak bones / osteoporosis	☐	☐	Acidity / stomach ulcer	☐	☐
Joint replacement (year: ____)	☐	☐	Fainting / giddiness	☐	☐
Arthritis	☐	☐	Mental health condition	☐	☐

Any other illness, operation or hospital admission

Please tick if any of these apply to you

☐ I take blood-thinning medicine (e.g. Ecosprin/aspirin, clopidogrel, warfarin, apixaban, rivaroxaban)

☐ I take medicine for weak bones — bisphosphonates or denosumab (e.g. Fosamax, Zoledronic acid, Prolia)

☐ I take steroids (e.g. prednisolone / Wysolone)

☐ I am on immunosuppressant medicine or have low immunity

☐ I have been told to take antibiotics before dental treatment

☐ I am pregnant — month: _____ ☐ I am breastfeeding

Current medicines — including any Ayurvedic, homoeopathic or herbal medicines and supplements

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☐ Prescription attached

Allergies

☐ Penicillin / amoxicillin ☐ Other antibiotic _____ ☐ Local anaesthetic (injection) ☐ Latex / rubber gloves

☐ Aspirin or painkillers ☐ Iodine / Betadine ☐ Metals _____ ☐ Food _____ ☐ Other _____

☐ No known allergy

What happened during the reaction?

Have you ever had a problem with general anaesthesia or sedation? ☐ Yes ☐ No

Details

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7 DENTAL HISTORY

Reason for today's visit

☐ Pain ☐ Check-up ☐ Cleaning ☐ Broken tooth ☐ Cosmetic / appearance ☐ Second opinion ☐ Follow-up

☐ Other _____

If in pain, describe (which tooth, since when, what makes it worse)

_____

_____

Date of last dental visit ____/____ Previous clinic / dentist _____

Please tick any that apply

☐ Bleeding gums ☐ Sensitivity to hot / cold / sweet ☐ Bad breath ☐ Loose teeth ☐ Food getting stuck between teeth

☐ Dry mouth ☐ Mouth ulcers that do not heal ☐ White or red patch in the mouth ☐ Burning sensation in mouth

☐ Difficulty opening the mouth fully ☐ Clicking or pain in the jaw ☐ Grinding teeth at night ☐ Difficulty chewing

☐ Unhappy with the look of my teeth ☐ Snoring

Dental treatment you have had before

☐ Filling ☐ Cleaning / scaling ☐ Root canal (RCT) ☐ Tooth extraction ☐ Wisdom tooth removal ☐ Cap / crown / bridge

☐ Denture ☐ full ☐ partial ☐ Braces / aligners ☐ Implant ☐ Gum treatment ☐ Teeth whitening

Have you ever had trouble getting numb with a dental injection? ☐ Yes ☐ No

How nervous are you about dental treatment? (1 = not at all, 10 = very nervous)

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

8 HABITS & ORAL CARE

Tobacco and areca nut — please answer honestly. This directly affects your oral health and the treatment we advise.

☐ Cigarette / bidi — number per day: _____ For how many years: _____

☐ Gutkha / khaini / zarda / mawa — times per day: _____ For how many years: _____

☐ Paan with tobacco ☐ Paan without tobacco ☐ Supari (areca nut) — times per day: _____ ☐ Snuff / gul / mishri

☐ Ex-user — quit in year: _____ ☐ No tobacco use

Alcohol ☐ Never ☐ Occasionally ☐ Regularly — how often: _____

Oral care

Brushing ☐ Once a day ☐ Twice a day ☐ Not daily

Using ☐ Toothbrush and paste ☐ Finger / manjan / tooth powder ☐ Datun / neem ☐ Electric brush

Do you use floss or an interdental brush? ☐ Daily ☐ Sometimes ☐ Never

Do you use mouthwash? ☐ Yes ☐ No

Source of drinking water ☐ Municipal supply ☐ Borewell / handpump ☐ RO or filtered ☐ Packaged / can

Have you or anyone in your family been told you have fluorosis (yellow-brown stains on teeth)? ☐ Yes ☐ No ☐ Not sure

Sweet or aerated drinks (cold drinks, packaged juice, sweet tea) per day _____

9 X-RAYS (RADIOGRAPHS)

☐ I consent to dental X-rays (IOPA, OPG, CBCT as required) being taken when the dentist considers them necessary for diagnosis and treatment planning. I understand the radiation dose is low and that the reason will be explained to me.

Do you have recent X-rays from another clinic? ☐ Yes — clinic: _____ ☐ No

☐ Please obtain my previous records and X-rays from the clinic named above.

10 FEES & CLINIC POLICY — PLEASE READ AND TICK

☐ Consultation and treatment fees are payable at the time of the visit unless agreed otherwise.

☐ Treatment plan and estimate — for treatment beyond consultation and cleaning, I will be given a written plan with an estimated cost. The estimate is a guide; if clinical findings change, I will be informed before any additional cost is incurred.

☐ Insurance — the clinic will assist with paperwork, but approval, the amount payable and any deduction are decided by my insurer or TPA. Any amount not covered is my responsibility.

☐ Appointments — please give at least [24] hours' notice to cancel or reschedule. Repeated missed appointments may attract a fee of ₹[ ].

☐ Payment modes accepted: cash / UPI / debit or credit card / net banking / EMI [delete as applicable].

☐ Multiple sittings — some treatments (RCT, crowns, implants, braces) need several visits. Leaving treatment incomplete can damage the tooth, and fees already paid may not be refundable.

11 CONSENT & DECLARATION

I confirm that the information given above is true and complete to the best of my knowledge. I will inform the clinic of any change in my health, medicines or contact details.

I understand and agree that:

- My personal and health data is collected to provide dental care, maintain clinical records, process payments and, where applicable, process insurance or government scheme claims.
- My data may be shared with the treating dentist and staff, dental laboratories, referred specialists, diagnostic centres, and my insurer, TPA or scheme authority where relevant to my care or claim.
- Clinical photographs, X-rays and models form part of my dental record.
- My data will be handled in accordance with the Digital Personal Data Protection Act, 2023. I may ask for access to my data, ask for corrections, or withdraw consent at any time by writing to the clinic. Withdrawing consent may affect the clinic's ability to continue treatment.
- Grievance contact: The Practice Manager, Sri Shankara Dental Clinic — privacy@srishankaradental.com

Optional — please tick if you agree

☐ Appointment reminders by SMS or WhatsApp

☐ Recall reminders for check-ups and cleaning

☐ Use of my de-identified clinical photographs for teaching or clinic publicity (entirely optional; you may withdraw at any time)

Note: this form registers you as a patient. Separate written consent will be taken before any surgical or major procedure.

Patient signature / thumb impression _____ Date ____/____/_____

If signed by parent, guardian or attendant

Name _____ Relationship _____

Signature _____ Date ____/____/_____

FOR CLINIC USE ONLY

Received by _____ Date ____/____/_____

ID verified ☐ Yes ABHA linked ☐ Yes Scheme / insurance verified ☐ Yes

Medical alerts entered in software ☐ Yes Details _____

Treating dentist _____ File no. _____

Records requested from previous clinic ____/____/_____ Received ____/____/_____

Notes

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