Pranati S. Chokshi, D.M.D., P.A.
11157 W. Colonial Drive ~ Ocoee, FL 34761
(407)654-9905

Patient Information

We appreciate the confidence you have placed with us to provide dental care.
All the information on this chart is necessary for our records and is strictly confidential.

Patient -First:_____ **MI:**_____**Last:**_____**Preferred:**_____

Address:_____**Apt #**_____**City:**_____ **State:**_____ **ZIP:**_____

DOB:_____ **Male / Female** **Marital Status:**_____ **Spouse Name:**_____

Home Phone (____)_____ **Cell Phone (____)**_____ **Work Phone (____)**_____**ext**_____

Employer:_____ **Work Address:**_____**City**_____**Zip**_____

E-mail:_____ **Social Security #:** _____ **Employer:** _____

Responsible Party/Policy Holder:_____ DOB_____Relation:_____

SSN:_____ **ID#** _____**Insurance Co:**_____ **Group #**_____

Please let us know how you heard about us: Friend/Relative_____ ☐ Signage ☐ Insurance Company

☐Yellow Pages ☐Advertisting ☐ Internet:(keywords used)_____ ☐ Other:_____

EMERGENCY CONTACT: _____ Phone:_____ Relation:_____

Dental Health History

The information you provide is important for your dental health. If there have been any changes in your health, please tell us. If you have any questions, do not hesitate to ask. Please answer YES or NO to the following questions:

	YES	NO
Are you having any discomfort?	☐	☐
Sensitivity to hot, cold, sweets, chewing?	☐	☐
Does dental treatment make you nervous?	☐	☐

Have you experienced any of the following problems?

Snoring problem	☐	☐
Bleeding gums	☐	☐
Bad breath	☐	☐
Grinding of teeth		
Jaw pain	☐	☐
Headaches	☐	☐

Do you have difficulty brushing your teeth due to the following?

Arthritis	☐	☐
Difficulty in reaching back teeth	☐	☐
Uncontrolled hand movement	☐	☐
Other:_____		

Patients with Denture or Partial:

Do you wear a denture/partial?	☐	☐
How old is your denture/partial?	☐	☐
Have you relined your dentures before?	☐	☐
Does your denture cause irritation or soreness?	☐	☐
Have your dentures ever broken or cracked?	☐	☐
If you wear a partial, did you ever break a clasp?	☐	☐
Do You use a denture cleaner?	☐	☐
Are your dentures loose?	☐	☐
Do you use any denture adhesive?	☐	☐

	YES	NO
Have you ever had Periodontal Therapy?	☐	☐
Are your teeth turning yellow or losing brightness?	☐	☐
Do you smoke? # of packs per day_____	☐	☐
Do you drink coffee or tea?	☐	☐

If I could change my smile I would make my teeth:

Whiter	☐	☐
Remove white spots	☐	☐
Close space/spaces	☐	☐
Replace stained front fillings	☐	☐
Change silver fillings to white	☐	☐
Repair chipped teeth	☐	☐
Replace missing tooth/teeth	☐	☐
Straighten teeth	☐	☐
Other_____		

Do you take fluoride supplements?	☐	☐
Do you prefer to save your teeth?	☐	☐

Date of last cleaning:_____
Are you experiencing pain at this time, if so where?_____

Please describe:_____

Please explain reason for your visit today: _____
_____
_____
_____

Patient/Guardian Signature: _____ **Date:_____**

rev-9/14

Time 8:39 AM | Pranati S. Chokshi D.M.D,P.A | Date 4/2/2015

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____