CASE HISTORY & INFORMED CONSENT FORM OF PATIENT

Date: Name of the Doctor:

Patient name:

Age: Gender:

Parent name/Relation:

Address for communication:

Contact number : Email Id:

Medical history :

History of Allergy:

Chief complaint:

Is this your / (your child's) first dental visit : Yes ☐ No ☐

Past dental history:

Extra oral examination:

Intra oral examination:

Quadrant number/Concerned Tooth number	1st quadrant	2nd quadrant	3rd quadrant	4th quadrant
Clinical finding				
Radiographic finding				
Provisional diagnosis				
Treatment plan				

Above mentioned demographic and medical history details of the patient provided by me are correct. I understand the details mentioned with respect to individual tooth. The treatment plan made for individual tooth has been explained to me thoroughly. I give my consent to go ahead with the above-mentioned treatment plan.

Patient Signature:
Date:

Parent Signature(In case of minor):
Date: