PATIENTS DETAILS – CONFIDENTIAL

Your Medical and Dental History

Providing Dentistry for all ages, our staff is dedicated to your health and smile

As a new/current patient we need to get to know you and your medical and dental history to provide you with the highest quality treatment.

Date / /

Surname:…… Given names:…….. Title:……..

Date of Birth:…… Email:……..

Address:…… Postcode:……

Ph:(Home)…… Ph:(Work)…… P :(Mobile)……

PRIVATE HEALTH FUND (Dental):…… How did you hear about us? ……

In case of emergency whom should we contact?

Name:…… Relationship:…….. Phone:……

Who is your General Practitioner?..... Phone:……..

Do you have any allergies? (e.g: Penicillin, Latex, Local anaesthetics, etc)

……

Are you taking any tablets or medicines at present OR INJECTIONS FOR YOUR BONES

……

Have you had or are you suffering from any of the following? (Please circle)***YES/NO specify*.**

- HEART TROUBLE/SURGERY/STROKE/PACEMAKER YES/NO
- OSTEOPOROSIS YES/NO
- HIGH BLOOD PRESSURE OR LOW BLOOD PRESSURE YES/NO
- EXCESSIVE OR PROLONG BLEEDING/ANTICOAGULANT YES/NO
- DIABETES YES/NO
- PROSTHETIC IMPLANT/JOINT REPLACEMENT YES/NO
- ARTHRITIS YES/NO
- THYROID DISORDER YES/NO
- HIV/AIDS/HEPATITIS YES/NO
- STOMACH/REFLUX OR DIGESTIVE CONDITION YES/NO
- ASTHMA YES/NO
- LIVER OR KIDNEY DISEASE YES/NO
- ARE YOU OR COULD YOU BE PREGNANT YES/NO
- RADIATION OR CHEMOTHERAPY YES/NO
- SLEEP APNOEA YES/NO
- RHEUMATIC FEVER YES/NO
- OTHER (SPECIFY) YES/NO

I have completed this form to the best of my knowledge, and will inform you at a subsequent appointment if my health status has changed.

Signed:…… THANK YOU