CONFIDENTIAL MEDICAL HISTORY FORM

To obtain the best and safest treatment, your dentist needs to know of any problems which may affect your treatment.

Title: Mr/Mst/ Mrs/ Miss/ Ms SEX: Male / Female DATE OF BIRTH: …………………

SURNAME: …………………………… FIRST NAME: ……………………………………

ADDRESS: ……………………………………………………………………………
POSTCODE: ………………………………..

CONTACT NUMBER:
HOME: ……………………… MOBILE: ………………………….. ….. WORK ……………………..

EMAIL: ……………………………………………………….. ARE YOU PREGNANT: YES / NO

OCCUPATION: …………..…………….. DATE OF LAST DENTAL VISIT: ….………………...

How did you find out about our practice? (eg. friend)……………………………………………
Did a Friend Recommended us? What is the Full name of the friend? ……………………………

***ARE YOU**: (PLEASE CIRCLE THE APPROPRIATE RESPONSE)

-Allergic to any Medicines, Food or Materials? Yes / No
If yes, please give details (ie.penicillin)………………………………………………

-Taking/Receiving any Treatment/Medication from your Doctor? Yes / No
If yes, please give details: …………………………………………………………………

***HAVE YOU:**
-Had Rheumatic Fever? Yes / No
-Any known Heart Condition? Yes / No
-Had a bad reaction to local or general anaesthetic? Yes / No
-Tested Positive for HIV? Yes / No
-Been hospitalised? Yes / No
-If there is any Medical Information the Dentist needs to know, Please Specify below:
……………………………………………………………………………………………

***DO YOU:**
-Have Diabetes or does anybody in your family? Yes / No
-Had Jaundice, Liver or Kidney Disease, or Hepatitis (A, B or C)? Yes / No
-Have Fainting Attacks, Giddiness, Blackouts or Epilepsy? Yes / No
-Bruise easily or have any Bleeding problems? Yes / No
-Smoke? Yes/No How many do you smoke per day?...............................
-Drink Alcohol? Yes/No How many units of Alcohol do you drink per week?.............................

PLEASE READ THE FOLLOWING STATEMENT AND SIGN BELOW

I am aware that I must pay any charges at the time of my treatment. I understand that the treatment I am undertaking requires a deposit and that should I fail to attend this appointment, arrive late (whereby my treatment cannot be carried out) or cancel without 24 hours notice, this deposit will be retained by the practice. The charges are as follows:

Hourly Rate: **£90.00** 30 Minutes: **£45.00** Hygienists: **£30.00**

Signed: …………………………………….. Date: …………………………..