

welcome

thank you for selecting us

Surname (Mr/Mrs/Miss/Ms)
Forename
Address
.....Postcode.....
Tel no. (home).....Tel no. (business)
Date of Birth.....Occupation

Certain medical conditions can affect dental treatment and vice versa

Please complete this form by ticking the appropriate boxes and answering the questions

All details will be strictly confidential

Do you have or have you ever suffered from:

- | | yes | no |
|-------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| Rheumatic fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| Any heart complaint, heart surgery or stroke? | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy or fainting attacks? | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic bronchitis or asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive bleeding? | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Any other serious illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you carry a medical warning card? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you allergic to any medicine, tablets, substances or latex? (list below) <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| at present taking any medicine or tablets? (list below in notes) .. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| pregnant. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| In the past 2 years have you undergone any operations? | <input type="checkbox"/> | <input type="checkbox"/> |
| been treated with hydro-cortisone or corticosteroids? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a joint replacement operation? | <input type="checkbox"/> | <input type="checkbox"/> |
| Please tick or tell the dentist if you are HIV positive | <input type="checkbox"/> | <input type="checkbox"/> |
| What is your average weekly consumption of alcohol? | | |
| If you smoke, what is your average per week? | | |

If 'yes' to any questions please supply details in 'Notes' below or use back of form

Name and address of your doctor:

Notes:

.....
.....
.....
.....

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.....
.....
.....

If you are not sure of any of the questions, or if your medical circumstances change, please inform the Dental Surgeon

Patients signature: Date

updates

Welcome

Please check that all the information on this form is still correct.
Record the review plus any changes below.

Date of review	Changes advised	Patient's Signature
Any Changes? Yes <input type="checkbox"/> No <input type="checkbox"/>		Dentist's Signature

Date of review	Changes advised	Patient's Signature
Any Changes? Yes <input type="checkbox"/> No <input type="checkbox"/>		Dentist's Signature

Date of review	Changes advised	Patient's Signature
Any Changes? Yes <input type="checkbox"/> No <input type="checkbox"/>		Dentist's Signature

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Any Changes? Yes <input type="checkbox"/> No <input type="checkbox"/>		Dentist's Signature

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Any Changes? Yes <input type="checkbox"/> No <input type="checkbox"/>		Dentist's Signature

Date of review	Changes advised	Patient's Signature
Any Changes? Yes <input type="checkbox"/> No <input type="checkbox"/>		Dentist's Signature