Medical and Dental History Form

Strictly Private and Confidential

Thank you for completing this form. It will only take a few moments and will give us vital information we need, to provide you with the care and attention you need. Please hand the completed form to the receptionist.

Full Name Mr Mrs Miss Ms Other: .....

Address: .....
.....
.....
.....
Post Code: .....

Home Tel: .....
Work Tel: .....
Mobile Tel: .....
Date of Birth: .....
Occupation: .....
Email.....

Your Doctor's name and address. .....
.....

Contact Preference for your check-up reminders, circle one: **Letter** **Text** **Email**

Approximate last visit to a dentist.....

Please circle as appropriate:

- Do you have any dental pain/discomfort at the moment? Yes / No
- Are you happy with the appearance of your smile? Yes / No
- Would you like to improve your smile? Yes / No
- Would you like to have whiter teeth? Yes / No
- Are you interested in having tooth coloured fillings? Yes / No
- Do your gums bleed when you brush your teeth? Yes / No
- Are you aware of the alternatives to dentures? Yes / No
- Would you like to have our easy payment options explained to you? Yes / No
- How did you hear about our practice?

  Convenient Location ☐

  Recommended by friend ☐

  Recommended by family ☐

  For emergency treatment ☐

  Referred by another Dentist ☐

  Yellow Pages ☐

  Internet (Website) ☐

  Other (please state) .....

- **Have you ever had or do you suffer from any of the following?**

Rheumatic Fever	☐	Stomach Ulcers	☐
Heart Attack	☐	High/Low Blood pressure	☐
Angina	☐	Jaundice	☐
Heart Murmur	☐	Hepatitis	☐
Asthma	☐	Diabetes	☐
Liver Disease	☐	Thyroid Problems	☐
HIV/AIDS	☐	Cold Sores/Herpes	☐

Fainting Attacks/Giddiness/Epilepsy ☐

- Are you presently under medical care or taking any medication? Please specify:

  .....

- Are you allergic to or made ill by any medication? .....
- Have you ever had any ill effects from penicillin or any other antibiotic?

  .....

- Have you ever had any ill effects from local anaesthetic?.....
- Do you suffer from any other allergy, e.g. latex? .....
- Have you taken steroids within the last 2 years? .....
- Is there a history of bleeding disorders within your family?.....
- Have you ever had a prolonged illness or hospitalisation? .....
- Are you pregnant?.....
- Do you smoke if yes how many per day?.....
- Drink alcohol if yes how many units a week?.....
- Is there any further information about your medical or dental history, which may be important? .....

I consent to messages regarding my appointments being left on my home answer phone/voicemail Yes / No

Please note that this information is strictly private and confidential. Whitgift Dental Practice complies with the 1998 Data Protection Act. This ensures that personal information is processed fairly and lawfully. Personal data about you is held within the group's computer system. The information is not accessible to the public and only authorised members of staff have access to it. Please ask our receptionist for further details.

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