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Patient Contact & Medical History Form

Patient Contact

The following questions regarding your medical history are designed to identify factors that may influence delivery of your dental care. All information will be treated with complete confidentiality.

Surname _____ Title _____ Gender ..... (F) (M)

Given Names _____ Preferred Name _____

Address _____

_____ Postcode _____

Mailing Address _____

_____ Postcode _____

Home Number _____ Mobile Number _____

Work Number _____ Date of Birth _____

Email Address _____

This practice will send recall reminder letters via email if listed. Otherwise by post.

Appointment confirmations will be by SMS where possible. Is this suitable? Tick choice ..... (Y) (N)

Please indicate preferred phone contact for calls. ..... (H) (M) (W)

Do you have private dental insurance? ..... (Y) (N) If yes, which fund? _____

Do other immediate family members attend this practice? ..... (Y) (N)

If yes, do you wish to be on the 1 account record? ..... (Y) (N)

Confidential Medical History

If you would prefer to discuss any particular medical information with the dentist, please tick here. ☐

Have you ever had or have now?

A history of Rheumatic Fever	Y	N	**Hip or joint replacement**	Y	N
High/Low Blood Pressure - please circle one	Y	N	**Asthma**	Y	N
Heart Condition - please discuss with dentist	Y	N	**Bleeding disorder**	Y	N
Heart Valve Problems	Y	N	**Chemotherapy / Radiotherapy**	Y	N
Pacemaker	Y	N	**Diabetes**	Y	N
Kidney / Liver disease	Y	N	**Epilepsy**	Y	N
Transplant	Y	N	**Thyroid Disease**	Y	N
Have you ever had a facial or jaw fracture?	Y	N	**Do you smoke?**	Y	N
Any other serious illness or disability?	Y	N	If yes, please list		

Have you ever had Hepatitis or been advised you may be a carrier? Y N

If yes, which one? _____

Is there a reason for you to suspect that you are in a risk category for infectious diseases.
Eg. HIV AIDS or any other immuno-compromising condition?

Are you under any treatment from a medical practitioner? Y N

Name of your medical practitioner _____

Please list any (& all) medication you may be taking at present (Including cold/flu tablets)

_____

Please list any known Allergies to drugs especially medicines, antiseptics, local anaesthetics, or preservatives

_____

Have you experienced problems of any kind during or after dental treatment?

_____

Ladies - Is there a possibility that you are Pregnant? Y N If yes, due date? _____

As antibiotics may influence the effectiveness of oral contraception please advise your dentist
if this may be pertinent in your case. Y N

Full Name _____

Signature _____ **Date** _____