Name:

Address:

Date of Birth:

Phone: Home: Work:

Mobile: E-mail:

Best way to contact (please circle) Home / Work / Mobile

Person responsible for fees, if not self: ……
(NB: Fees are payable at each visit – if this presents a problem, please let us know).

Occupation: …… Dental Insurance company ……..

Medical History

Name of your General Practitioner:.....Phone:.....

Purpose of visit today:.....

Have you had any of the following?

Heart problems/murmur	o Yes	Allergies to anaesthetics	o Yes
Blood pressure	o Yes	Allergies to penicillin	o Yes
Artificial joints	o Yes	Allergies to medications	o Yes
Rheumatic fever	o Yes	Allergies to latex	o Yes
Circulatory problems	o Yes	Anemia or other blood disorders	o Yes
Radiation treatment	o Yes	Diabetes	o Yes
Excessive bleeding	o Yes	Asthma	o Yes
Excessive bruising	o Yes	Hepatitis A B C D E	o Yes
Ulcers (stomache)	o Yes	Epilepsy	o Yes
Sinus trouble	o Yes	Liver or kidney problems	o Yes
Tumor history	o Yes		

Are you currently taking any prescribed medication? o Yes

If yes, please specify:
……
(e.g. hormone replacement therapy, high blood pressure, corticosteroids)

Have you been hospitalised recently? o Yes

If yes, please specify: ……..

Ladies: Are you pregnant? o Yes What is the due date?.....

Does food get jammed between your teeth? o Yes Do you bite your lips or cheek often? o Yes
Does your jaw click or hurt? o Yes Do you smoke? oYes
Do you feel you grind your teeth? o Yes Do you think you have occasional bad breath? o Yes
Have you ever had orthodontic treatment? o Yes Do you wear a night guard? o Yes
Does floss ever tear between your teeth? o Yes Do you experience sensitivity with hot/cold? o Yes
Have you ever had gum disease? o Yes Do your teeth ever hurt when you bite hard? o Yes
Have you ever had your bite adjusted? o Yes
Do your gums ever bleed when you brush your teeth? o Yes
Do you suffer from headaches or neck aches? o Yes
If so, how frequently?
Weekly o Twice a month o Monthly o Less than monthly o

Does having dental treatment worry you? o Yes

If yes, how can we make your visit more comfortable?
.....

Are you taking any alternative medicines? Yes € No €

If yes, please specify: ……..……
(e.g. vitamin supplements, herbal medicine, homeopathic remedies)

Have you been advised to have antibiotic cover prior to dental treatment? Yes € No €

Is there anything else you would like us to know? ……..

Is there anything you would like to discuss in private with your dentist? Yes € No €

Consent for treatment

I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anaesthetics', sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand that payment is due at the time of service unless other arrangements have been made.
I authorise that this data may be reviewed by team members of the dental practice.

Signature: ……..……..... Date: ……..

Parent/responsible party’s signature:..

Relationship to patient:...