

# Medical history form

Please complete, sign and give to your dentist

To provide you with the most appropriate advice, we need to know about aspects of your health which may affect your dental treatment. The information that you provide will be treated in the strictest confidence.

Surname *(Block capitals)*

Forenames

Title

Date of birth

Male / Female

Address

Postcode

Telephone (home)

(work)

(mobile)

Email address

Doctor's name

Doctor's address

Telephone

Date of your last dental treatment

## ARE YOU:

Yes No

Receiving treatment from a doctor, hospital, clinic or alternative therapist?

*Please give details*

Taking any medicines or drugs (tablets, ointments, injections, inhalers)?

*Please list on back page*

Allergic to any medicines, foods or materials (e.g. penicillin or latex)?

*Please give details*

Pregnant or likely to be pregnant?

## HAVE YOU, AS A CHILD OR SINCE:

Yes No

Had rheumatic fever?

Had jaundice, hepatitis, liver disease or kidney disease?

Ever been told you have a heart problem, angina, blood pressure problems, or had a heart attack or stroke?

Ever had your blood refused by the Blood Transfusion Service?

Had a bad reaction to a general or local anaesthetic?

Had a joint replacement or other implant?

Been advised to take antibiotics (prophylaxis) before dental treatment?

Been hospitalised? *If yes, what for, and when?*

**Medical history form**

**DO YOU:**

**Yes No**

Have arthritis?

Have osteoporosis?

*If yes, please give details of medication you are on, or have taken for the disease?*

Have a pacemaker, or have you had any form of heart surgery?

Suffer from hay fever, eczema or any other allergy?

Suffer from bronchitis, asthma or other chest condition?

Have fainting attacks, giddiness, blackouts, or epilepsy?

Have diabetes, or does anyone in your family?

Have any infectious disease, including CJD or HIV?

Bruise easily or have had extended bleeding following a tooth extraction, surgery or injury?

Carry a warning card?

Ever get cold sores?

Smoke? *If so, how many per day?*

Drink alcohol? *If so, how many units per day?*

Are there any other aspects concerning your health that you think we should know about?

*Please give details*

### Terms of business:

- All treatment in the practice is carried out under private contract with the treating dentist or hygienist unless otherwise advised.
- We do ask patients to settle any dental charges in full at the end of each visit. For some treatments we will ask for payment in advance of any treatment provided. We accept all major credit cards (not American Express), cash, and cheques (but only for payments in advance), and we have the facility to process Switch and Debit cards.
- Dental loans are subject to status, and are contracts between the patient and the relevant loan company.
- In the event of the practice having to pursue outstanding debts, we reserve the right to charge for our administrative costs, any outside agency fees and accrued interest.
- We do levy a charge if appointments are not kept, or if the appointment is cancelled within 24 hours (one working day) of the allocated time. For appointments of an hour or longer we require at least two working day's cancellation notification (working days are classed as Monday to Friday inclusive, not including any Bank Holidays).
- All treatment guarantees are subject to our 'Guarantee Terms and Conditions'.
- From time to time we may ask patients to participate in our practice surveys which we use to improve services and help identify any staff training needs. In addition we may record telephone calls for training purposes.

*I have given a full account of my medical history and my present medical health and I agree to update that information should there be any changes. I further agree to the terms of business.*

### Signed

Self  Parent/guardian  Date

### Updating of medical history

Date	No changes	Changes

### List of medication/notes

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45 Furnace Drive, Furnace Green, Crawley RH10 6JD  
t 01293 527627 f 01293 582320 e info@smilecaredentalcentre.co.uk