ROYAL ARSENAL DENTISTS

Patient Confidential Medical History Form

Please complete both sides of this form

Title Mr/Mrs/Miss/Ms Full Name ____________________ Date of Birth ____________

Address ____________________ Postcode ____________

Tel. ____________________ E-mail ____________________

Questions

Please complete your medical history below. All details will be strictly confidential.
Certain medical conditions can affect dental treatment and vice versa.

Question	YES	NO
Are you (female) currently pregnant or trying to become pregnant?	☐	☐
Are you currently receiving treatment from a doctor, hospital or clinic?	☐	☐
Do you carry a medical warning card?	☐	☐
Do you suffer from allergies to any medicine (e.g. Penicillin), substances (e.g. latex/rubber) or foods?	☐	☐
Do you suffer from or have ever suffered from eczema or hayfever?	☐	☐
Do you suffer from bronchitis, asthma, or any other chest conditions?	☐	☐
Do you suffer from fainting attacks, giddiness, blackouts or epilepsy?	☐	☐
Have you ever suffered from heart problems, angina, blood pressure problems, or strokes?	☐	☐
Are you diabetic (or is anyone in your family)?	☐	☐
Do you suffer from arthritis?	☐	☐
Do you suffer from bruising or persistent bleeding after injury, extraction or surgery?	☐	☐
Do you suffer from any infectious diseases (including HIV and hepatitis)?	☐	☐
Have you ever had rheumatic fever or chorea?	☐	☐
Have you ever had liver disease (e.g. jaundice, hepatitis), or kidney disease?	☐	☐
Have you ever had any other serious illness?	☐	☐
Have you ever had blood refused by the Blood Transfusion Service?	☐	☐
Have you ever had a bad reaction to general or local anaesthetic?	☐	☐
Have you ever had a joint replacement or other implant?	☐	☐
Have you ever had treatment that required you to be in hospital?	☐	☐
Have you ever had heart surgery?	☐	☐
Have you ever had brain surgery?	☐	☐
Have you ever received growth hormone treatment before the mid 1980's?	☐	☐
Do you smoke?	☐	☐
If so, how many cigarettes do you smoke on average in a week?		
If you are male, do you regularly drink more than 21 units of alcohol per week?	☐	☐
If you are female, do you regularly drink more than 14 units of alcohol per week?	☐	☐
Do you have any close relatives with Creutzfeldt Jakob disease?	☐	☐
Are you currently taking any prescribed medicines (e.g. tablets, ointments or inhalers, including contraceptives and hormone replacement therapy?)	☐	☐

If **YES** to any questions please supply additional details below:

Name and address of your doctor

Notes

Dental Questionnaire

When was your last dental visit? ______________________

	YES	NO
Are you currently experiencing pain or discomfort?	☐	☐
Have you recently lost or broken a tooth or filling?	☐	☐
Are you concerned about metal fillings?	☐	☐
Are you concerned about the appearance of your teeth?	☐	☐
Do your gums bleed when you brush your teeth?	☐	☐
Have you seen a hygienist on a regular basis in the past?	☐	☐

How did you hear about Royal Arsenal Denitsts?

☐ Online Advert ☐ Online search ☐ Flyer / Voucher ☐ Website

☐ Facebook/Twitter ☐ Friend ☐ Press / Magazine ☐ Billboard

Terms and Conditions

I wish to register/re-register as a patient at Royal Arsenal Dentists
I understand and agree to the following:

- That the agreement by which I will be given dental treatment is agreement between the dentists and myself
- That, under my treatment plan my treatment will be paid for after each visit
- That under my treatment plan, I may be required to pay in advance for certain types of treatment
- That, I may be charged a fee of £25 for each 15 minutes of an appointment with the dentist missed or cancelled without 24 hours prior notice.
- That, as a courtesy we will remind you of your appointment a few days before. However, where we are unable to reach you and you fail to keep your appointment without 24hrs prior notice a late cancellation fee will be payable.

PRACTICE USE ONLY

Patient Signature ______________ or Guardian Signature ______________ Date ________

Dentists ______________ Signature ______________ Date ________

Please advise us in the future of any change in your medical history or any medications you may be taking.

Date	Date	Date	Date	Date
Patient Signature	Patient Signature	Patient Signature	Patient Signature	Patient Signature
Dentist Signature	Dentist Signature	Dentist Signature	Dentist Signature	Dentist Signature

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