confidential medical history

Please complete this form in full answering all questions and giving details where necessary.
This will enable us to treat you safely. Please bring this form with you to your first appointment.

Thank You

Your Details

Surname .....

Forename(s) .....

Title.....Date of birth.....

Address .....

.....

.....

.....Postcode .....

Telephone (home).....

Telephone (work) .....

Telephone (mobile) .....

Email .....

Occupation .....

Doctor (name and address) .....

.....

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We hope you will be very satisfied with the care you receive in our practice. We would like to know what made you choose us.

- ❑ WALKED BY
- ❑ WORD OF MOUTH
- ❑ INTERNET
- ❑ FRIEND/FAMILY
- ❑ CORPORATE INTRANET
- ❑ DENTIST
- ❑ PROMOTION
- ❑ NEWSPAPER AD
- ❑ FLYER
- ❑ RADIO AD
- ❑ ANOTHER REASON, PLEASE SPECIFY

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Dental History

How long is it since you last visited a dentist ☐ years ☐ months

How do you normally feel about visiting the dentist?

☐ Relaxed ☐ A little nervous ☐ Very nervous ☐ Terrified

Are you currently:

	Yes	No	Details:
Pregnant	❑	❑	
Receiving treatment from a doctor, hospital or clinic	❑	❑	
Taking any medicines, e.g. tablets, ointments, injections or inhalers. Including contraceptives, and hormone replacement therapy	❑	❑	
Carrying a warning card	❑	❑	

Do you suffer from:

Allergies to any medicines (e.g. penicillin), substances (e.g. rubber/latex) or food	❑	❑	
Hay fever or Eczema	❑	❑	
Bronchitis, Asthma or other chest condition	❑	❑	
Fainting attacks, giddiness, blackouts or Epilepsy	❑	❑	
Heart problems or Angina	❑	❑	
Blood pressure problems	❑	❑	
Diabetes (or does anyone in your family)	❑	❑	
Persistant bleeding following injury, tooth extraction or surgery	❑	❑	
Any infectous diseases such as HIV or Hepatitis	❑	❑	
Arthritis	❑	❑	
Cold sores	❑	❑	
Mouth ulcers	❑	❑	

Drinking

How many units of alcohol do you drink per week (A unit is _ a pint of lager, a single measure of spirit or a single glass of wine)

.....per week

Smoking

Do you smoke tobacco products or have you smoked in the past

now.....per day
past.....per day

Are you currently:

	Yes	No	Details:
Pregnant	❑	❑	
Receiving treatment from a doctor, hospital or clinic	❑	❑	
Taking any medicines, e.g. tablets, ointments, injections or inhalers. Including contraceptives, and hormone replacement therapy	❑	❑	
Carrying a warning card	❑	❑	

Do you suffer from:

Allergies to any medicines (e.g. penicillin), substances (e.g. rubber/latex) or food	❑	❑	
Hay fever or Eczema	❑	❑	
Bronchitis, Asthma or other chest condition	❑	❑	
Fainting attacks, giddiness, blackouts or Epilepsy	❑	❑	
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now.....per day
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Form completed by ☐ Self ☐ Parent ☐ Guardian

Signature.....Date.....

Medical history update

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.

Date	Change(s)	Patient's initials

I wish to register as a patient at Malmin Health Centre

I understand and agree to the following:

That under the agreement by which I will be given dental treatment (My treatment plan), is an agreement between the dentist and myself, and is not an agreement by which Malmin is a party.

That under my treatment plan, my treatment will have been paid for in total by the last visit.

That under my treatment plan, I may be required to pay in advance for certain items of treatment.

That under my treatment I may be charged a fee of £15.00 for each 15 minutes of an appointment missed or cancelled without 24h hours prior notice.

Signed_____Print Name_____