Gentle Dental

excellence quality beauty innovation

Confidential Medical and Dental History Form

To obtain the best and safest dental care, your dentist needs to know of any problems which may affect your treatment

Title: Mr / Mrs / Miss / Ms / Mast / Dr	Full name:	
Address:		
		Post Code:
Tel No. (home):	(work):	
Email:	Occupation:	
Date of Birth:	Expectant Mother Yes / No	Time since last treatment:
Doctor's Name & Surgery:	Last Dentist:	

	YES	NO	DETAILS
ARE YOU:			
1. Attending or receiving treatment from a doctor/clinic/hospital?			
2. Taking any medicines from your doctor (tablets/creams/injections)?			
3. Taking or have taken steroids in the last two years?			
4. Allergic to any medicines, foods or materials? (e.g. rubber)			
5. Anxious about dental treatment? If yes, how anxious?			
HAVE YOU (as a child or adult)			
1. Had rheumatic fever or chorea?			
2. Had jaundice, liver, kidney disease, HIV, vCJD or hepatitis?			
3. Ever been told that you have a heart murmur or heart problem, angina, high or low blood pressure, heart attack.			
4. Had any blood tests, inoculations etc?			
5. Ever had your blood refused by the blood transfusion service?			
6. Had a bad reaction to general or local anaesthetic?			
7. Had a joint replacement?			
8. Been hospitalised? If 'yes', what for and when?			
DO YOU			
1. Have arthritis?			
2. Have a pacemaker or have had any form of heart surgery?			
3. Suffer from hay fever, eczema or any other allergy?			
4. Suffer from bronchitis, asthma or other chest condition?			
5. Have fainting attacks, giddiness, blackouts or epilepsy?			
6. Have diabetes, or does anyone in your family?			
7. Bruise easily or following a tooth extraction, surgery or injury have you or your family bled so as to cause you to be worried?			
8. Carry a warning card?			
9. Are there any other aspects concerning your health that you think we should know about?			
10. Smoke? If so, how many daily?			
11. Expect your teeth to last your lifetime?			
12. Have a high alcohol intake? How many units do you have a week?			

Please write down overleaf anything that you think may help us know how you would like to be looked after.

Remember - this is your dental practice and we are here to look after you. If you have questions or problems, please let us know. Gentle Dental is an Approved Training Practice.

PAST DENTAL HISTORY	YES	NO
Are you unhappy with any dental treatment received in the past?		
Are there any dental problems which concern you now?		
Do you have any dental pain?		
Are your teeth sensitive to hot and cold?		
Do your gums bleed?		
Are any of your teeth mobile?		
Do you get any problems with your jaw joint?		
Is there anything about the appearance of your teeth that you would like to change?		
If you have a denture, is it satisfactory?		

WOULD YOU LIKE TO KNOW MORE ABOUT ANY OF THE FOLLOWING	YES	NO
Cosmetic treatment?		
Botox or Restylane for improvement of facial contour?		
Preventative treatment and advice for pregnant or nursing mothers?		
Preventative treatment and advice for children or young adults?		
Orthodontics (straightening teeth)?		
White fillings for back teeth?		
Crowns, bridges or veneers that look like natural teeth?		
Better quality or stronger plastic dentures?		
Metal dentures?		
Implants?		
Hypnosis for extremely nervous patients?		
Intravenous sedation for dental treatment?		
Gold restorations?		
The difference between NHS and Private treatment?		
Needle free local anaesthetic?		
How Denplan could apply to you?		
Your monthly fee for the above?		

If there is any other information that you feel that we should know, please write it here.

Completed by Self/Guardian; I hereby apply to become a patient of Gentle Dental. I undertake to settle all fees when due either at the time of treatment or in advance. I understand that interest may be paid on overdue accounts and that seriously overdue accounts may incur extra fees. If treatment is to be paid by a third party i.e. under insurance or under NHS I remain liable for those fees until the account is settled.

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

(Completed at subsequent visits) Have there been any changes in your health, medicines, injections or tablets since your last visit? ..... Date ..... Date ..... Date ..... Date