green arbor
dental practice

CONFIDENTIAL MEDICAL AND DENTAL FORM

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

FULL NAME:……DATE OF BIRTH……/……/……..
ADDRESS:……
……..PHONE NO...……
YOUR DOCTOR'S NAME:……
ADDRESS:……..……..……..
……..……..……...

IF YOU ANSWER YES TO ANY OF THE FOLLOWING QUESTIONS, PLEASE GIVE DETAILS BELOW OR OVERLEAF

Are You Attending Or Receiving Treatment From A Doctor, Hospital, Or Clinic?.....YES / NO

Are You Currently Taking Any Medication Or Tablets Prescribed By A Doctor? ……...YES / NO

If YES, please gives details:
……
……
……
……

Have You Any Allergies?…..……..……..……. YES / NO

Have You Ever Had Rheumatic Fever Or Chorea?……..……..…….....YES / NO

Have You Ever Been Told You Have A Heart Murmur?…….....YES / NO

Have You Ever Had Heart Problems, Heart Surgery / A Pacemaker?…….....YES / NO

Do You Have Heart Disease, High Blood Pressure Or Angina? ……....YES / NO

Do You Have Chronic Bronchitis, Asthma Or Other Lung Disease?…….....YES / NO

Do You Suffer Excessive Bleeding Or Bleeding Disorders?……..……..YES / NO

Have You Ever Had Jaundice, Hepatitis Or Liver Disease? ……. YES / NO

Are You Diabetic?……..……...YES / NO

Have You Taken Steroids In The Last 12 Months?…….....YES / NO

Could You Be Pregnant?……..……..YES / NO

Do You Have Any Infectious Diseases Such As HIV, Hepatitis C?.....YES / NO

Do You Smoke?..…..……..……..……..……..YES / NO

How Much Alcohol Do You Consume Per Week?.....

I am happy to be contacted to remind me of future appointments:……YES / NO

My preferred contact method is: (Please complete)

Home Phone:……

Mobile Phone:……

I am happy to have messages left:……YES / NO

PATIENT'S SIGNATURE:……TODAY'S DATE:……/……/……..

DENTIST'S SIGNATURE: ……TODAY'S DATE:……/……/……..

DISCLAIMER: We are regulated by the Care Quality Commission (CQC), who may contact you and ask you questions about your experience with the practice.