

Patient History Form

Please inform reception if there are any changes in your contact details.

Title..... Name.....

Date of Birth / /

Address.....

.....

.....Postcode.....

E-mail address.....

Telephone.....Mobile.....

Occupation.....

Doctor's Name and Practice:

Dr.....

Practice.....

.....

Which of the following statements best describes your feelings about visiting the dentist?

I feel relaxed I feel a little anxious I feel very anxious or nervous

Are there any dental procedures which have frightened you in the past? If so, please outline what happened?

.....

Could you tell us your reason for choosing our practice?

.....

Approximately how long is it since you last visited a dentist?

.....

Have you left another practice to come here?

Yes No

If you are happy to tell us why, please do so.

.....

Our practice offers both NHS and private care and your dentist can explain what choices are available to you after your check up.

Do you have a preference for NHS treatment
Private treatment

Do you think you might qualify for free treatment on the NHS?.....

If you are not eligible for free dental treatment the charges are payable before the treatment is provided and can be made with cash, cheque, credit or debit card. An estimate of the charges can be provided following your check-up.

Please give details of any physical impairment you feel we should be aware of (eg, Visual or hearing impairment, unable to climb stairs etc)

.....
.....
.....

Heart Conditions

Yes No

- High Blood Pressure
- Heart Surgery
- Pacemaker Fitted
- Heart Murmur
- Thrombosis
- Angina
- Other Heart conditions:

Chest Conditions

Yes No

- Bronchitis
- Emphysema
- Pneumonia
- Asthmatic
- Chest Surgery
- Cystic Fibrosis
- Pleurisy
- Other Chest Condition:

Please give details.....

Please give details.....

Blood Conditions

Yes No

- Bleeding
- Hepatitis
- H.I.V.
- Anaemia
- Sickle Cell
- Haemophilia

Other Blood Conditions:
Please give details.....

Do you receive regular Blood Test?

If so, why?.....

Other Conditions

Yes No

- Diabetes
- Liver Disease/Jaundice
- Kidney Disease
- Epilepsy
- History of Radiation Therapy
- History of Dizziness/
Blackouts/Fainting
- Cancer
- History of severe mental illness
- Have you ever had a bad reaction
to Local or General Anaesthetic
- Hiatus Hernia
- Arthritis
- Serious Illnesses/Hospitalisation
What was this?
- Other Condition:
Please give details.....

Allergies

Do you have ANY history of an allergic reaction to any Medication, Latex, Hayfever, Eczema, Dental Materials, Food/Drinks or anything else?

Yes No

-

If yes, please give details

.....

Other Information

Yes No

- Pregnant
- Medical Warning Card
- Smoker, If yes, how many times a day?
- Betel Nut or Tobacco chewing
- Alcohol, If yes, how many times a week?

