ADELAIDE HOUSE
DENTAL PRACTICE

## Your personal details

Title (Mr, Mrs, Miss, Ms, other title)

First name(s) *(please include all forenames in full)*

Surname

Address

Postcode

Date of birth

Home telephone number | Work telephone number

Mobile telephone number | Email address

Occupation

How did you hear about us

## Details of contact in case of emergency

Name | Telephone

## Insurance details (other than the practice plan - DPAS)

Are you insured for any dental care? ☐ Yes ☐ No (optional)
If yes, under which insurer?

## Medical history questionnaire – confidential

**Please fill in this section carefully. It is important that your dentist has your full medical history. Please ask your dentist's advice if you are unsure about any of the questions**

GP name

Address

Telephone number

Have you been seen by your GP during the past year? ☐ Yes ☐ No

Are you presently under medical care or taking medication (tablets, medicines or drugs)? If yes, please list: ☐ Yes ☐ No

Are you taking or have you taken steroids in the last two years? ☐ Yes ☐ No

Have you ever had a prolonged illness or been hospitalised? ☐ Yes ☐ No

Have you had any major/serious operations or radiation therapy? ☐ Yes ☐ No

**The next two questions are applicable to women only**

Are you pregnant or is it possible you may be pregnant? ☐ Yes ☐ No

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Are you taking the contraceptive pill? Certain medication may compromise its effectiveness. ☐ Yes ☐ No

## Medical history questionnaire (continued)

Do you have any of the following?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Rheumatic fever | ☐Yes ☐No | High blood pressure | ☐Yes ☐No | Low blood pressure | ☐Yes ☐No |
| Congenital heart lesion/ cardiac pacemaker | ☐Yes ☐No | Asthma or hay fever | ☐Yes ☐No | Hiatus hernia/ Stomach trouble | ☐Yes ☐No |
| Heart attack/ Angina/stroke | ☐Yes ☐No | Jaundice, hepatitis, liver disease | ☐Yes ☐No | Diabetes – Blood sugar issues | ☐Yes ☐No |
| Heart murmur | ☐Yes ☐No | HIV/AIDS | ☐Yes ☐No | Epilepsy | ☐Yes ☐No |
| Bone or joint disease | ☐Yes ☐No | | | | |

Did you as a child or since have brain surgery, growth hormone treatment before the mid-1980s or have a close relative with CJD? ☐ Yes ☐ No

Have you ever had any ill effects following dental treatment? ☐ Yes ☐ No

Have you or any relation had any severe prolonged bleeding problems? ☐ Yes ☐ No

Have you had any allergies to medicines (eg penicillin, substances or materials such as latex) ☐ Yes ☐ No

Have you had any ill effects from any other antibiotic? ☐ Yes ☐ No

Have you had any ill effects from local anaesthetic? ☐ Yes ☐ No

Do you currently smoke/chew any tobacco products, pan/betel nut or similar products? ☐ Yes ☐ No
**If yes**, approximately _____ per day

Have you previously smoked? ☐ Yes ☐ No

Do you drink alcohol? **If yes**, approximately _____ units per week ☐ Yes ☐ No

Is there any other information about your medical history which may be important? If yes please list below including allergies: ☐ Yes ☐ No

## Dental history

What prompted you to seek dental care at this time? (New patients only)

How long is it since your last thorough dental examination with x-rays? (New patients only)

What words best describe your past dental experiences?

☐ Caring ☐ Relaxed ☐ Modern ☐ Painful ☐ Stressful ☐ Sympathetic ☐ Rushed
☐ Good value ☐ Uncomfortable ☐ High-tech ☐ Old fashioned ☐ No choice

Has the fear or discomfort kept you from regular visits? ☐ Yes ☐ No

Have you experienced any discomfort in your teeth recently? ☐ Yes ☐ No

Are you aware of any *grinding* or *clenching* of your teeth? Do your jaws ever *hurt* or *click*? *Please circle*

Do your gums; *bleed easily*, feel *tender/irritated*? Are you troubled with *bad breath/taste*? *Please circle*

Would you like to know more about any of the following?

☐ Teeth whitening ☐ Teeth straightening ☐ Replacing missing teeth ☐ Softening lines/wrinkle reduction

**I understand a minimum of 2 working days must be given to change or cancel an appointment. A cancellation fee will apply if less than 2 working days notice is given.**

| **Patient signature** (or parent/guardian signature if under 16): | **Dentist/dental professional signature**: |
|---|---|

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| | |
|---|---|
| **Date**: / / | **Date**: / / |