HIGHGROVE DENTAL CARE

Confidential Medical History Form

This provides the dentist with important information required for your Dental treatment and Oral Health Care.

Title..... First Name..... Surname.....
Date of Birth..... Email.....
Address..... Post Code.....
Home Phone..... Mobile.....
Occupation..... Work Phone.....

Details of person to contact in an emergency:
Name..... Tel.....
Medical Doctors Name..... Phone (If known).....

Are you currently	**Yes**	**No**	**Details**
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed tablets, medicines, inhalers etc?			
Carrying a medical warning card?			
Pregnant or possibly pregnant?			
HIV positive?			

Have you ever suffered from

Allergies to medicines, substances (eg latex/rubber/penicillin) or foods?			
Bronchitis, asthma or other chest condition?			
Epilepsy?			
Heart problems eg rheumatic fever?			
Diabetes?			
Persistent bleeding following injury, tooth extraction or surgery?			
Liver Disease (jaundice, hepatitis) or kidney disease?			
Any other serious illness or infectious disease?			
Blood pressure, angina, heart attack?			
A bad reaction to general or local anaesthetic?			
Treatment that required you to be in hospital?			
CJD or have a close relative with CJD?			
Are you a smoker?			If Yes, how many per day?

Name of Last Dentist (for new patients)	
Are you exempt from NHS charges?	**Yes/No** Details:

Date	Signed: Patient / Parent / Guardian	Date	Signed: Patient / Parent / Guardian

Referred By: Another Patient ☐ Website ☐ Street Sign ☐ Other ☐