

Confidential Medical History Questionnaire

Welcome

In order to help us meet all of your dental healthcare needs, please complete the following medical and dental history form. Please ask a member of staff if you need any assistance or have any questions.

Personal Details

Title Mr Mrs Miss Ms Other

First Name

D. O. B.

Home Tel.

Surname

Occupation

Mobile Tel.

Email Address

Work Tel.

Address

Postcode

Medical History - Do you have or have you had any of the following:

Heart Condition including heart attack/ heart murmur/ angina?

Yes

No

High or low blood pressure?

TB or chest problems including asthma/ bronchitis?

Rheumatic fever or chorea?

Liver or kidney problems including hepatitis/ jaundice?

Excessive bleeding after cuts or bruises?

Fainting attacks/ giddiness/ blackouts?

Headaches/ migraines?

Reaction to local or general anaesthetic?

Any infectious diseases, HIV or hepatitis

Do you have any close relatives with CJD?

Blood refused by the Blood Transfusion Service?

Growth hormone treatment since 1980?

Ever get cold sores?

Bruise easily or suffer from excessive bleeding?

If you have had any other serious illness, please provide details below:

Do you suffer from any of the following?

	Yes	No	Yes	No
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Hayfever	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>

Are you currently attending or receiving any treatment from your doctor or specialist?

Are you allergic to any medicines, tablets, substances or latex?

If you are a smoker, how many cigarettes do you smoke daily?

If you drink alcohol, how many units of alcohol do you drink in an average week?





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Your medical history continued...

Doctor's Details					
Name	<input type="text"/>		Tel.	<input type="text"/>	
Address	<input type="text"/>		Postcode	<input type="text"/>	
Please provide details of any medication you are taking					
<input type="text"/>					
Female Patients Only					
Are you pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you taking the oral contraceptive pill?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Registration details					
Would you like to know more about how our City Bridge Dental Care Membership Plan can help you make savings in the annual cost of your dental care?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do you have any dental insurance? (including HSA/ Boots/ Denplan/ company scheme)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Your name and address details may be shared with our patient plan provider.					

How did you hear about us?					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If patient/ friend/ other, please provide name:		
Yellow Pages	Passing by	Returning Patient	<input type="text"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Internet	Leaflet	Other	Patient/ Family		

Signature	
Cancellation & Missed Appointment Policy	
A minimum of 48 hours notice for any changes to your appointments is required. Missed or failed appointments mean that other patients cannot be seen and lead to higher charges. To reduce this City Bridge Dental Care has a strict policy of charging for missed or failed appointments. We may also request a deposit for long appointments.	
I certify I have read and understood the above information and have answered all the questions accurately. I understand that any incorrect information can be dangerous to my health and I will inform my dentist of any changes. I understand the City Bridge Dental Care cancellation and missed appointment policy. I agree to be responsible for the payment in full of all services rendered on my behalf.	
Patient Signature	Dentist Signature
<input type="text"/>	<input type="text"/>
Date	Date
<input type="text"/>	<input type="text"/>