BALHAM DENTAL

Confidential Registration and Medical History Sheet

Title Surname	
Forenames	Date of Birth
Email address	
Address	
	Postcode
Tel (home)	Mobile/work
Occupation	Private Dental Insurance? YES/ NO Provider:
Doctors name and address	NHS number

Person to contact in case of emergency
Name
Tel(home) Mobile/work

Why did you leave your previous Dentist?.....

.....Date of last dental check up……..

Your General Health

Are you fit and well? NO/ YES

Are you registered disabled NO/ YES

Your Smile: Please answer between 1 (don't agree) and 9 (fully agree).

Are you happy with your smile? 1 2 3 4 5 6 7 8 9 (please circle)

Are you happy with the colour and shape of your teeth? NO/YES

Do your gums bleed when you brush them? NO/ YES

Risk factors for gum disease or oral cancer

Do you chew betal nut/tobacco leaves? NO/ YES

Do you smoke NO/ YES …..per day

Are you an ex-smoker NO/ YES …./day ….years

Do you drink alcohol NO/ YES …..per week

Do you drink more than 8 units of alcohol in one session more than once a month? Y/N

Are you or do you have?	Yes	No	Please give details
Pregnant			
Taking <u>any</u> medication including self-prescribed remedies			
Heart condition, angina, high blood pressure, arrhythmia or pacemaker?			
Diabetic?			
Asthma or any breathing difficulties			
Allergic to any medicine, metals, food or latex?			
Been in Hospital in the last 3 years? or had a general anesthetic?			
Epilepsy or experienced fainting attacks?			Date of last attack:
Any adverse reactions to local or general anesthetics?			
Had prolonged bleeding following tooth extraction, or bruise easily?			
Hepatitis A, B or C or HIV or Aids			
Received steroid therapy in the last 2 years?			
Suffer from digestive problems, eating disorders or gastric reflux?			
History of Dura Matter Graft or Hormones therapy before 1992?			
Undergone Radiotherapy? Site?			
Creutzfeldt-Jakob disease in the family			
History of mental illness?			
Attend or receive any treatment from a Doctor/Hospital/Clinic? Carry a warning card?			

Form completed by: Self / Parent / Guardian **(please circle)**

Signature: …… Date…….

Sign to update: Patient's signature: Dentist's initials:	Date:	Date:

The practice can contact me about my treatment:	By email ☐		By text ☐	
Receive important practice announcements / updates	Yes ☐	No ☐	By email ☐	By post ☐
Receive details of new treatments and services	Yes ☐	No ☐		