

Private and Confidential Medical History - Adult

Full name of patient Mr/Mrs/Miss/Ms			Date of birth
Address (including postcode)			
Home phone number		Mobile phone no.	
Work phone number		Email address	
Name of next of kin			Relationship to patient
Address (if different from above)			Home phone number Mobile phone number

Dentist's name			
Address			
Phone number			
Doctor's name			
Address			
Phone number			

It is essential for us to have an up to date record of the general health of all our patients in case this may have any effect on possible treatment. Have you ever suffered from the following (please tick and complete where applicable):

YES	NO	
		Any illnesses requiring antibiotics prior to dental treatment (e.g. Rheumatic fever)?
		Any other heart problems (heart murmur, replacement heart valve etc)?
		Any allergies e.g. antibiotics, nickel, latex etc? Have you had allergy test of confirm this? YES/NO
		Hepatitis? Which type
		HIV infection
		Bleeding problems?
		Chest complaints e.g. Asthma? State medication being taken
		Diabetes? How is it controlled?
		Epilepsy? State medication being taken
		Any other illnesses, conditions, diseases? Please state
		Are you prone to fainting?
		Are you taking any medicines/pills at the moment? Please state
		Are you undergoing any medical treatment? Please state
		Have you ever been in hospital? Please state
		Are you likely to be pregnant?
		Do you get any pains in your jaws or teeth?
		Do you suffer from an eating disorder? e.g. Anorexia or Bulimia
		Have you been seen by an orthodontist before?
		Have you ever had braces or orthodontic treatment?
		Have you had any injury to your teeth? Please give details:

Please inform us of any unique facts not covered by the above:

Please state the names of any family members, adult or child, that you would like to register with us for orthodontic treatment:

Name	Age

Please state the names of any family members who have had orthodontic treatment:

Name	Age	Approx dates

My main concerns are (please tick):

- | | |
|-----------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Crowded or crooked teeth | <input type="checkbox"/> Mismatched centre lines |
| <input type="checkbox"/> Gaps between the teeth | <input type="checkbox"/> Abnormal jaw bones |
| <input type="checkbox"/> Missing teeth | <input type="checkbox"/> Difficulty eating |
| <input type="checkbox"/> Teeth stuck in gum | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Teeth sticking forward | <input type="checkbox"/> Problems cleaning my teeth |
| <input type="checkbox"/> Abnormal or incorrect bite | <input type="checkbox"/> Other _____ |

How did you hear about us? (please tick)

- | | |
|------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Friend/family | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Magazine advert | <input type="checkbox"/> Other _____ |

I understand that if I agree to any private treatment and fail to arrive or cancel with less than 24 hours notice I may be charged accordingly.

Signature of patient _____ **Date** ____/____/____