smiles better ORTHODONTICS

Patient Number

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

I give permission to being contacted by the surgery via telephone, email and letter **(please delete as appropriate)**		
I give permission for photographs to be taken for clinical purposes only **(if photographs need to be sent to a third party as part of the treatment I am aware that I will need to give further permission for this)**	YES	NO
I am aware of the Data protection code of practice which is available on request.		

My main concerns are (please tick):

- ☐ Crowded or crooked teeth
- ☐ Gaps between the teeth
- ☐ Missing teeth
- ☐ Teeth stuck in gum
- ☐ Teeth sticking forward
- ☐ Abnormal or incorrect bite
- ☐ Mismatched centre lines
- ☐ Abnormal jaw bones
- ☐ Difficulty eating
- ☐ Speech problems
- ☐ Problems cleaning my teeth
- ☐ Other_____

How did you hear about us? (please tick)

☐ Friend/family ☐ Internet
☐ Magazine advert ☐ 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 ___/_____/_____