smiles better ORTHODONTICS

Patient Number

Private and Confidential Medical History - Child

Full name of patient **Master/Miss**		**Date of birth**
Address **(including postcode)**		
Home phone number		**Patient NHS number**
Name of next of kin		**Relationship to patient**
Email address		**Mobile phone number**
Address **(if different from above)**		**Home phone number**

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

It is essential 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 as applicable):

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

Signature_____ **Date** ___/_____/_____**Relationship to Patient**_____

For practice use: Medical history checked by:

Name	Relationship to patient	Signature	Date
Name	Relationship to patient	Signature	Date