

# PATIENT DETAIL FORM

PLEASE COMPLETE THIS FORM AS FULLY AS POSSIBLE

*All information collected is used to ensure that your health and safety is maintained and that the best treatment possible is provided. Your personal details are used for internal purposes only and are kept strictly confidential.*

Name: \_\_\_\_\_ Title (Mr/Mrs/Ms/Dr etc): \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Ph: \_\_\_\_\_ (BH) Ph: \_\_\_\_\_ Mob: \_\_\_\_\_  
Postal Address (If different to above): \_\_\_\_\_  
\_\_\_\_\_  
Email: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Person Responsible for Fees: \_\_\_\_\_ Ph: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph: \_\_\_\_\_  
Medical Doctor: \_\_\_\_\_ Ph: \_\_\_\_\_  
Health Insurance: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

## HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE TICK OR GIVE DETAILS:

High Blood Pressure	___	Thyroid Problems	___
Heart Ailment/Surgery	___	Excessive Bleeding or Blood Disorder	___
Rheumatic Fever	___	Asthma/Chest/Breathing problems	___
Epilepsy	___	Hepatitis A/B/C.	___
Tuberculosis	___	Stomach/Bowel problems (e.g. ulcer)	___
AIDS/HIV	___	Any hip/prosthetic surgery	___
Kidney Disease	___	Any other illnesses: _____	___
Diabetes	___	_____	___

Do you smoke? (please circle) Yes/No      How many? \_\_\_\_\_/per day?  
Would you like to stop?      Yes/No

Do you or your partner have concerns regarding snoring?      Yes/No  
Do you wake up in the morning still feeling tired or unrefreshed?      Yes/No  
Are you concerned about the SIZE, SHAPE or COLOUR of your teeth?      Yes/No

Female patients, are you pregnant?      Yes/No  
Are you presently under medical care?      Yes/No  
Are you taking medication or tablets for any medical conditions? (please list) \_\_\_\_\_

Do you have allergies to any medicines or products (e.g. Penicillin, Dairy foods, Latex) \_\_\_\_\_

*I have completed this form to the best of my knowledge, & understand that failure to make a full disclosure may place ME at undue medical risk. I understand that clinical records, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to assist in my treatment, & consent to this. I also give my permission for the practice to use the above contact details to send me appointment reminders.*

Signed \_\_\_\_\_

Date: \_\_\_\_\_