PATIENT DETAILS FORM

Personal Details

First Name _____ Surname_____

Preferred Name _____ Date of Birth _____./_____/_____

Address _____

_____Postcode _____

Email _____

Phone (H) _____ Phone (M) _____

Occupation_____ Health fund _____

Who recommended you to our practice_____

Medical and Dental History

Do you have any concerns with your teeth or mouth?

_____

Do you require antibiotic cover before dental procedures? Y / N

Do you take any blood thinners or have a bleeding disorder? Y / N

Have you had an adverse reaction to local anaesthetic? Y / N

Have you been hospitalised in the last 12 months? Y / N

Are you a smoker? Y / N

Are you pregnant? If yes, how many months? _____

Are you taking any medications at present (including vitamins)? Please list:

_____

Do you have any allergies? (eg. penicillin, latex) Please list:

_____

Do you have or have you had any of the following medical conditions? Y/N

- Blood borne disease eg. HIV, Hepatitis
- Prosthetic joint eg. Hip
- Prosthetic heart valve
- Diabetes
- Stroke
- Epilepsy
- Cancer
- High or low blood pressure
- Tuberculosis
- Bronchitis, emphysema or other lung disease
- Bone disease inc osteoporosis, osteonecrosis
- Asthma
- Kidney disease
- Cardiac Pacemaker
- Rheumatic Fever
- Stomach/digestive condition
- Thyroid disease
- Liver disease
- Heart disease

Who is your general practitioner?_____

Patient Signature/Guardian if under 18:

_____ Date: _____

Jamestown Dental

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