

BALHAM DENTAL

Confidential Registration and Medical History Sheet

| | |
|--------------------------|--|
| Title | Surname |
| Forenames | Date of Birth |
| Email address | |
| Address | |
| | Postcode |
| Tel (home) | Mobile/work |
| Occupation | Private Dental Insurance? YES/ NO Provider: |
| Doctors name and address | |
| | NHS number |

| | |
|--|-------------|
| Person to contact in case of emergency | |
| Name | |
| Tel(home) | Mobile/work |

Why did you leave your previous Dentist?.....
Date of last dental check up.....

Your General Health

Are you fit and well? NO/ YES
 Are you registered disabled NO/ YES
Your Smile: Please answer between 1 (don't agree) and 9 (fully agree).
 Are you happy with your smile? 1 2 3 4 5 6 7 8 9 (please circle)
 Are you happy with the colour and shape of your teeth? NO/YES
 Do your gums bleed when you brush them? NO/ YES

Risk factors for gum disease or oral cancer

Do you chew betel nut/tobacco leaves? NO/ YES
 Do you smoke NO/ YESper day
 Are you an ex-smoker NO/ YESdayyears
 Do you drink alcohol NO/ YESper week
 Do you drink more than 8 units of alcohol in one session more than once a month? Y/N

| Are you or do you have? | Yes | No | Please give details |
|--|-----|----|----------------------|
| Pregnant | | | |
| Taking <u>any</u> medication including self-prescribed remedies | | | |
| Heart condition, angina, high blood pressure, arrhythmia or pacemaker? | | | |
| Diabetic? | | | |
| Asthma or any breathing difficulties | | | |
| Allergic to any medicine, metals, food or latex? | | | |
| Been in Hospital in the last 3 years? or had a general anesthetic? | | | |
| Epilepsy or experienced fainting attacks? | | | Date of last attack: |
| Any adverse reactions to local or general anesthetics? | | | |
| Had prolonged bleeding following tooth extraction, or bruise easily? | | | |
| Hepatitis A, B or C or HIV or Aids | | | |
| Received steroid therapy in the last 2 years? | | | |
| Suffer from digestive problems, eating disorders or gastric reflux? | | | |
| History of Dura Matter Graft or Hormones therapy before 1992? | | | |
| Undergone Radiotherapy? Site? | | | |
| Creutzfeldt-Jakob disease in the family | | | |
| History of mental illness? | | | |
| Attend or receive any treatment from a Doctor/Hospital/Clinic? Carry a warning card? | | | |

Form completed by: Self / Parent / Guardian (**please circle**)

Signature: Date.....

| | | |
|----------------------|-------|-------|
| Sign to update: | Date: | Date: |
| Patient's signature: | | |
| Dentist's initials: | | |

| | | |
|--|--|--|
| The practice can contact me about my treatment: | By email <input type="checkbox"/> | By text <input type="checkbox"/> |
| Receive important practice announcements / updates | Yes <input type="checkbox"/> No <input type="checkbox"/> | By email <input type="checkbox"/> By post <input type="checkbox"/> |
| Receive details of new treatments and services | Yes <input type="checkbox"/> No <input type="checkbox"/> | |