Welcome

Thank you for selecting us

Surname (MR/Mrs/Miss/Ms)
Forename
Address

Postcode
Tel no (home)………………………… Tel no (work)……………………..
Date of birth…………………………... Occupation………………………

Certain medical conditions can affect dental treatment and vice versa
Please answer all the questions correctly

All details will be strictly confidential		
Do you or have you ever suffered from	**Yes**	**No**
Rheumatic fever?		
Any heart complaint. Heart surgery or stroke?		
Diabetes?		
Epilepsy or fainting?		
Chronic bronchitis or asthma?		
Hepatitis?		
Excessive bleeding?		
High blood pressure?		
Any other serious illness?		
Do you carry a medical warning card?		
Are you allergic to any medicine, tablets, substances or latex?		
Are you taking any medicine or tablets?		
Are you pregnant or breast feeding?		
In the past 2 years have you undergone any operations?		
Been treated with hydro-cortisone or corticosteroids?		
Have you ever had a joint replacement operation?		
Are you HIV positive?		
What is your average weekly consumption of alcohol		
If you smoke what is your average per week		

Name and address of your doctor **Notes**

Patients signature…………………………………….Date