PATIENT MEDICAL HISTORY DETAILS

Title:		Email:	
Surname:		Mobile:	
First Name(s):		Other Contact:	
Date of Birth:		Next of Kin	
Physical Address		Postal Address:	

List of Medications:

Medical Conditions

Allergies ☐	Cancer ☐	Bone Conditions ☐	Stroke ☐
Bleeding Disorders ☐	Chemotherapy ☐	Artificial Joints ☐	Ulcers ☐
Heart Condition ☐	Radiation ☐	Epilepsy ☐	Mental Health ☐
Rheumatic Fever ☐	Steroid Therapy ☐	HIV/Aids ☐	
Lung Problems ☐	Diabetes ☐	Hepatitis (A,B,C) ☐	
Antibiotic Cover ☐	Kidney Disease ☐	Smoker ☐	
Other/Explain if any ticked boxes:			

Dental Concerns

Pain on Tooth ☐	Discoloured Teeth ☐	Can't Floss ☐	Silver Fillings ☐
Pain on Gums ☐	Rough/Sharp Teeth ☐	Bleeding Gums ☐	Teeth Spaces ☐
Pain when Bites ☐	Chipped Tooth ☐	Bad Breath ☐	Missing Teeth ☐
Pain in Jaw Joint ☐	Holes in Teeth ☐	Colour Change ☐	Crowded Teeth ☐
Sensitivity (Cold) ☐	Food Trapped ☐	Sore Tongue ☐	
Sensitivity (Hot) ☐	Floss Tears ☐	Teeth Grinding ☐	
Other/Explain if any ticked boxes:			

I hereby consent for diagnostic aids (photographs, X-rays, etc.) to be taken and for dental treatment to be performed on me/my child I understand that full payment is required on the day of treatment			
Full Name:		Signature:	
		Date:	