ASHBURTON
FAMILY DENTAL

PATIENT HISTORY SHEET

PERSONAL DETAILS

Title: ..... Surname: ..... First name: .....
Sex: ☐ M ☐ F Date of Birth: ..... Occupation: .....
Home address: ..... Phone (home): .....
..... Postcode: ..... Phone (mob): .....
Email: .....
Emergency contact: ..... Phone: ..... Relationship: .....
Person responsible for Fees: .....
Address (if different to above): .....
Do you have dental insurance? ☐ Y ☐ N If yes, name of insurer: .....
How did you hear about this practice?

☐ Live nearby
☐ Internet - Google
☐ Yellow Pages
☐ Friend .....
☐ Internet - Other
☐ Other .....

MEDICAL HISTORY

Do you suffer or have suffer in the past from any of these?

☐ High blood pressure
☐ Heart ailment
☐ Rheumatic fever
☐ Asthma, chest or breathing problems
☐ Tuberculosis
☐ Stomach or bowel problems
☐ Kidney disease
☐ Diabetes
☐ Thyroid problems
☐ Excessive bleeding or blood disorder
☐ Epilepsy
☐ Hepatitis
☐ HIV/AIDS
☐ Osteoporosis

Do you smoke? ☐ Y ☐ N How many? ...../day Would you like to stop? ☐ Y ☐ N
Do you have any artificial hip, heart valve or other prosthetic implant? ..... ☐ Y ☐ N
Are you taking any drugs, medicines or tablets? (Please list) ..... ☐ Y ☐ N
.....
Females patients, are you pregnant? ☐ Y ☐ N
Do you have allergies (e.g. Penicillin, Latex, Food?).....
Other medical conditions .....
.....

DENTAL HISTORY

How many times do you normally brush your teeth a day? ..... Do you floss and how often? .....
When was your last dental visit? .....
Why did you leave your last dentist? .....
Do you currently have any dental concerns? .....
.....
Is there anything that you would like to change about your teeth or their apperance? .....
.....
.....
Are you interested discussing or receiving further information about any of these dental treatment(s)?

☐ Teeth whitening .....
☐ Veneers .....
☐ Dental implants.. .....
☐ Other .....

Have you had any past problems with dental treatment? .....
.....

I have completed this Questionnaire to the best of my knowledge, and understand that failure to make a full discretion may place ME at undue medical risk. I give permission for the practice to use the above contact details to send me appointment and check-up reminders.

Signed: ..... Date:.....