

**CONFIDENTIAL INFORMATION - PLEASE HAND THIS COMPLETED FORM TO RECEPTION**

**PATIENT INFORMATION**

A response to each of the following questions will enable us to provide you with the best oral health care.  
**PLEASE PRINT IN BLOCK LETTERS**

SURNAME: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_ SECOND NAME: \_\_\_\_\_

PREFERRED TITLE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ POST CODE: \_\_\_\_\_

POSTAL ADDRESS: \_\_\_\_\_ POST CODE: \_\_\_\_\_

TELEPHONE: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Mobile: \_\_\_\_\_

PREFERRED METHOD OF CONTACT:  Home  Work  Mobile  Email

OCCUPATION: \_\_\_\_\_ EMAIL: \_\_\_\_\_

Have you been referred by a dentist? Yes / No Dentist's name: \_\_\_\_\_

If not, how did you hear about BOH? Friend/Colleague (Name \_\_\_\_\_)  
 Family member Yellow/White Pages City News Internet/website  
 Other: \_\_\_\_\_

Regular Medical Practitioner's Name and Address \_\_\_\_\_

Name and address of person responsible for payment (or, please write "self") \_\_\_\_\_

**MEDICAL HISTORY**

Do you have or have you previously had any of the following conditions? **Please tick Yes or No.**

	Yes	No		Yes	No
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding following any surgery or tooth extractions	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Previous Jaw injuries	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Teeth dislodged or traumatised in accidents	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Past treatment for cancer	<input type="checkbox"/>	<input type="checkbox"/>
High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Current treatment for cancer	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Do you have an illness requiring blood transfusions?	<input type="checkbox"/>	<input type="checkbox"/>
Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Allergies _____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Ladies, are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Are you presently being treated by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is there any subject you would like to discuss with the dentist in private?	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>			
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>			
Other (please give details) _____	<input type="checkbox"/>	<input type="checkbox"/>			

Have you been told by your doctor that you require antibiotic cover for dental treatment? \_\_\_\_\_

Please list **ALL** medication you are currently taking \_\_\_\_\_

Patient's or Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_