Dentist on Collins ™ – Patient History

Please take care to fill out this form completely. We rely on all your information to be able to provide you with appropriate dental services.

Privacy Policy – *We collect the information set out below in order to provide you with dental services. We will keep your information secure and confidential. If necessary, we may pass your information on to other health practitioners for a second opinion or referral purposes. We may also be required by law to provide your information to outside agencies. Our complete Privacy Policy is available on request at reception.*

Surname: .....Title: (e.g., Mr/Ms/Mrs/Miss/Dr/Prof etc.) (optional)

Other Names: ..... Preferred Name: ..... Date of Birth: ...../...../.....

Home Address: .....

.....Postcode: .....

Telephone No.: .....

Email Address: .....

Name of Parent or Guardian (if applicable): .....

Name of Person responsible for Fees: .....

Address if different to above: .....

.....Postcode: .....

Emergency Contact: ..... Telephone Number: .....

Medical Doctor: ..... Telephone Number: .....

New Patients: How did you find out about us? .....

What is your preferred method of communication? ☐ SMS ☐ E-mail ☐ Phone Call

Have you ever had any of the following? Circle Y or N

High blood pressure:	**Y / N**	Diabetes:	**Y / N**	Type I Type II	
Heart ailment:	**Y / N**	Thyroid problems:	**Y / N**	Epilepsy:	**Y / N**
Rheumatic fever:	**Y / N**	Tuberculosis:	**Y / N**	Asthma:	**Y / N**
Blood Borne Virus	**Y / N**	Kidney disease:	**Y / N**	Hepatitis:	**Y / N**
Osteoporosis	**Y / N**	Have you ever been prescribed bisphosphonates			**Y / N**
Back or neck problems	**Y / N**				

Excessive bleeding or blood disorder: **Y / N** Stomach or bowel problems (e.g., Reflux Ulcer Crohn's): **Y / N**

Details:.....

Do you have an artificial hip, knee, heart valve or other prosthetic implant? **Y / N**

Details:.....

Do you have: Normal Liver Function? **Y / N** Normal Kidney Function? **Y / N**

Do you smoke? ..... If so, how many a day? .....

Please Turn Over

Is it possible that you are pregnant? **Y / N** Due Date: ……/……../…….

List any other previous illnesses: ……

……

Do you wear a night splint? **Y / N**

Have you ever had problems with dental treatment? **Y / N**……

……

Do you: Snore? **Y / N** If yes, do you use a CPAP Machine? **Y / N**

Have sensitive teeth? **Y / N** Do you suffer from a dry mouth? **Y / N**

Please list all medicines or products you are allergic to (e.g., Penicillin, Latex): ……

……

Have you ever had an adverse reaction with medication? **Y / N** If yes please list medication and nature of reaction:……

Do you have an epi-pen? **Y / N**

Do you have Dental Extras Insurance? **Y /N** If yes please make this known to reception when you return this form.

Any other relevant medical history? ……

Medicines

There are many medications that may impact upon your oral health or the treatment we plan for you. Please indicate any medications that you are currently taking or have taken recently (including natural therapies). Alternatively, a list from your GP can be attached.

Are you on any blood thinners such as Warfarin, Xarelto or Aspirin? **Y / N**

Is there anything else you would like to discuss with the dentist in private? **Y / N**

© **ON FUTURE VISITS PLEASE ADVISE ANY CHANGES TO THE ABOVE**

□ **I agree to be responsible for payment of all fees and understand that payment is due at the time the service is rendered.**

Signature _____ Date ___/___/_____

OFFICE USE ONLY

Checked by: R Skinner Signed…… Date: ……../……../……..

Scanned by: …… Date: ……/……../……..