ORION
DENTAL & IMPLANT CENTRE

Confidential Medical and Dental History Form

To obtain the best and safest dental care, we need to know of any problems which may affect your treatment

Title: Mr/Mrs/Miss/Ms/Dr Full name: Date of birth:

Address: Post code:

Telephone Number; Home: Mobile: Work

Email address:

Preferred contact preference: Home/mobile/email

Occupation: Your last dental appointment?

Doctors name and address:

Next of Kin; Name: Relationship: Contact number

	Yes	No	Details
ARE YOU: An expectant mother?			
Attending or receiving treatment from a doctor/clinic/hospital?			
Taking any medicines from your GP?			
Taking or have taken steroids in the last two years?			
Allergic to any medicine, foods or materials?			
Anxious about dental treatment?			
HAVE YOU (as a child or adult) Had rheumatic fever or Chorea?			
Had Jaundice, liver, kidney disease, HIV, vCJD or hepatitis?			
Ever been told that you have a heart murmur or heart problem, angina, high or low blood pressure, heart attack?			
Had any blood tests, inoculations etc?			
Ever had your blood refused by the blood transfusion service?			
Had a bad reaction to general or local anaesthetic?			
Had a joint replacement?			
Been hospitalised? If 'yes' what for and when?			
DO YOU Have arthritis?			
Have a pacemaker or have had any form of heart surgery?			
Suffer from hayfever, eczema or any other allergy?			
Suffer from bronchitis, asthma or other chest condition?			
Have fainting attacks, giddiness, blackout or epilepsy?			
Have diabetes, or does anyone in your family?			
Bruise easily after tooth extraction, surgery or injury or do you or your family have bleeding disorders?			
Carry a warning card?			
Do you ever get cold sores?			
Smoke? If so, how many a day?			
Drink alcohol? if yes, how many units of alcohol do you drink per week? (A unit is half a pint of beer, a single measure of spirit or a single glass of wine)			

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	Yes	No	Details
Is there any other relevant medical information we should know about?			
DO YOU Use dental floss or other inter dental cleaning aid?			
Use a mouthwash?			
Have halitosis or bad breath?			
Use a manual or electric toothbrush?	Manual or Electric		
How often do you brush your teeth?			

PAST DENTAL HISTORY	Yes	No
Are you unhappy with any dental treatment received in the past?		
Are there any dental problems which concern you now?		
Do you have any dental pain?		
Are your teeth sensitive to hot and cold?		
Do your gums bleed?		
Are you teeth mobile?		
Do you suffer from clicking, cracking and/ or pain in your jaw joints?		
Do you Grind, squeeze or clench your teeth together?		
Is there anything about the appearance of your teeth that you would like to change?		
If you have dentures, are you happy with them?		
Are you aware of areas in your mouth where food gets stuck between your teeth?		
Do you have any missing teeth which you would like to replace?		
Have you seen a hygienist before?		

WOULD YOU LIKE TO KNOW MORE ABOUT ANY OF THE FOLLOWING	Yes	No
Dental Implants?		
Cosmetic treatment/tooth whitening?		
Intravenous sedation for dental treatment?		
White fillings?		
Better quality dentures?		
Botulinum toxin for improvement of facial contour?		
Preventative treatment and advice for children or young adults?		
Preventative treatment and advice for pregnant or nursing mothers?		
About our monthly practice plan?		

How did you hear about us?	Website	Google	Word of mouth	Used to be a patient
Walked by	Advertisement:			Other:

Is there any other information that you feel that we should know:

Patient Signature_____ Date: / / Completed by Patient/Guardian/Parent

Dentist Signature_____ Date: / /