Patient Pre-Registration Forms

Please return these completed forms to the clinic so that registration, payment and an appointment can be organised for you.

No.1 VICTORIA TERRACE
Dental Clinic

Name	
Sex	
Date of Birth	
Address	
Contact Number	**Home**
	Mobile
Email	
Next of Kin and Contact Number	
Occupation	
Registered GP Practice	
Previous Registered Dental Practice	
Last Dental Visit Date	

Medical History Form

Name ____________ Signature__________Date________

Please accurately complete this form. A new medical form is required for each course of treatment.

Are You Currently	**Yes**	**No**	**Details**
Receiving treatment from a Doctor, Hospital or Clinic? Please specify location.			
Taking any prescribed or unprescribed medicines? Continue overleaf if insufficient space.			
Carry a medical warning card?			
Pregnant (include due date)?			
Breast Feeding?			
Have You Ever Been Diagnosed With			
Allergies to any Medicines, Substances or Foods?			
Hay Fever or Eczema?			
Bronchitis, Asthma or other Chest Condition?			
Fainting Attacks, Giddiness, Blackouts, Epilepsy?			
Autism, ADHD or any Learning Disabilities?			
Heart Problems, Angina, Blood Pressure Problems or Stroke?			
Diabetes?			
Arthritis?			
Any other serious illness including Cancer?			
Brusing or Persistent Bleeding After Injury, Tooth Extraction or Surgery?			
Any Infectious Diseases including HIV and Hepatitis			
Rheumatic Fever or Cholera?			
Liver or Kidney Disease?			
Have You ever Had			
Blood Refused by the Blood Transfusion Service?			
A bad reaction to General or Local Anaesthetic?			
A joint replacement or other implant?			
Treatment requiring hospitalisation?			
Heart Surgery?			
Do You			
Currently Vape, Smoke or chew Tobacco Products? Or have you in the past? Specify per day.			
Do you drink Alcohol? Specify units per week.			