Please complete this form; it enables us to treat you safely. All information will be kept confidential. It will not be copied or transmitted to a third party without your consent. We may contact you as a reminder or to discuss your treatment with us. If you have any questions please ask your dentist.

MEDICAL HISTORY

Surname: .....

First name: .....

Mr / Mrs / Miss / Ms / Other (Please specify) .....

Date of birth: .....

Address: .....

.....

.....

Postcode: .....

Telephone: (home) .....

(mobile) .....

Your doctor's name & address: .....

.....

.....

01276 474702

www.orchardcottagedental.co.uk

ARE YOU:	Yes	No
Receiving any treatment from a doctor or hospital?	☐	☐
Taking any regular / prescribed medication?	☐	☐
If so, please list below:		
Pregnant or maybe pregnant?	☐	☐
Carrying a medical warning card?	☐	☐

HAVE YOU EVER SUFFERED FROM:	Yes	No
Allergies to any medicines like antibiotics?	☐	☐
Diabetes?	☐	☐
Fainting attacks, blackouts or epilepsy?	☐	☐
Bronchitis, asthma or other chest condition?	☐	☐
Persistent bleeding after an extraction or surgery?	☐	☐
Heart problems, angina, blood pressure, stroke?	☐	☐
A bad reaction to general or local anaesthetic?	☐	☐
Liver disease (jaundice, hepatitis) or kidney disease?	☐	☐
Any other serious illness or infectious disease?	☐	☐
Blood being refused by the Blood Transfusion Service?	☐	☐
Anything that may affect your treatment with us?	☐	☐
Do you smoke? If so how many each day?	☐	☐
Do you drink alcohol? If so, how many units per week?	☐	☐
I give permission to leave telephone messages	☐	☐

Completed by: Self ☐ Parent ☐ Guardian ☐

Signature:

Date:

Orchard Cottage Dental
82 Guildford Rd, Lightwater, Surrey GU18 5RY
phone: 01276 474702
web: www.orchardcottagedental.co.uk