confidential medical history

Please complete this form in full answering all questions and giving details where necessary.
This will enable us to treat you safely. Please bring this form with you to your first appointment.
Thank You

Your Details

Surname .....

Forename(s) .....

Title..... Date of birth .....

Address .....

.....

.....

..... Postcode .....

Telephone (home) .....

Telephone (mobile) .....

Email .....

Occupation .....

Employer* .....

*Some companies are entitled to 15% corporate discount.

Doctor (name and address) .....

.....

.....

.....

We hope you will be very satisfied with the care you receive in our practice. We would like to know what made you choose us.

- ☐ WALKED BY
- ☐ INTERNET
- ☐ FRIEND/FAMILY
- ☐ PROMOTION
- ☐ FLYER
- ☐ A BOARD / POSTER
- ☐ SOCIAL MEDIA
- ☐ FACEBOOK ADVERT
- ☐ Another reason, please specify

.....

Do you have dental insurance

☐ Yes ☐ No

If yes, which insurer? .....

In the event of an emergency please contact;

Name.....

Contact Number.....

Dental History

How long is it since you last visited a dentist

☐ years ☐ months

How do you normally feel about visiting the dentist?

☐ Relaxed ☐ A little nervous ☐ Very nervous ☐ Terrified

Are you currently:	Yes	No	Details
Pregnant	☐	☐	
Receiving treatment from a doctor, hospital or clinic	☐	☐	
Taking any medicines, e.g. tablets, ointments, injections or inhalers. Including contraceptives, and hormone replacement therapy	☐	☐	
Taking any self-prescribed medication?	☐	☐	
Carrying a warning card	☐	☐	
Taking or ever taken Bisphosponate medication (e.g for treatment of osteoporosis)	☐	☐	
Do you suffer from:			
Allergies to any medicines (e.g. penicillin), substances (e.g. rubber/latex) or food	☐	☐	

	Yes	No	Details
Hay fever or Eczema	☐	☐	
Bronchitis, Asthma or other chest condition	☐	☐	
Fainting attacks, giddiness, blackouts or Epilepsy	☐	☐	
Heart problems or Angina	☐	☐	
Blood pressure problems	☐	☐	
Diabetes (or does anyone in your family)	☐	☐	
Persistant bleeding following injury, tooth extraction or surgery	☐	☐	
Any infectous diseases such as HIV or Hepatitis	☐	☐	
Arthritis	☐	☐	
Cold sores	☐	☐	
Mouth ulcers	☐	☐	

Drinking

How many units of alcohol do you drink per week (A unit is _ a pint of lager, a single measure of spirit or a single glass of wine)

Smoking

Do you smoke tobacco products or have you smoked in the past

Have you ever had	Yes	No	Details
Rheumatic Fever	☐	☐	
Liver disease (Hepatitis)	☐	☐	
Blood refused by the transfusion service	☐	☐	
A bad reaction to general or local anaesthetic	☐	☐	
Heart Surgery	☐	☐	
Brain surgery	☐	☐	
Growth hormone treatment before 1985	☐	☐	
A close relative with CJD	☐	☐	
Any other serious illness	☐	☐	

Details

.....per week

now.....per day

past.....per day

Occlusal screening	Yes	No	Details
Do you clench or grind your teeth	☐	☐	
Do your jaws or teeth ache when you wake up	☐	☐	
Do you have headaches, neck, shoulder or back pain	☐	☐	
Do you have a painful or clicking jaw joint	☐	☐	
Do you chew only on one side of your mouth	☐	☐	

Aesthetic evaluation

Are you happy with your teeth and their appearance	☐	☐	
Are you self conscious about your teeth when you smile	☐	☐	
Do you have any discoloured teeth or fillings you are concerned about	☐	☐	
Are you concerned about wearing dentures	☐	☐	

Form completed by ☐ Self ☐ Parent ☐ Guardian

Signature ..... Date .....

Data Protection

Here at Malmin we take your privacy seriously and will only use your personal information to contact you regarding your treatment or appointment information. This includes appointment reminders, recall appointments and treatment plans.

Please see www.malmin.co.uk/privacy for more information about how we collect, use and protect your data.

However occasionally we would like to contact you with details of the latest prevention advice and treatment discounts exclusive to existing patients. If you consent to us contacting you for this purpose please tick here ☐

I wish to register as a patient at Malmin Healthcare

I understand and agree to the following:

That under the agreement by which I will be given dental treatment (My treatment plan), is an agreement between the dentist and myself, and is not an agreement by which Malmin is a party.

That under my treatment plan, my treatment will have been paid for in total by the last visit.

That under my treatment plan, I may be required to pay in advance for certain items of treatment.

That under my treatment I may be charged a fee of £15.00 for each 15 minutes of an appointment missed or cancelled without 24 hours prior notice.

Signed..... **Print Name**.....