Thanet House Dental Care

Title (Mr/Mrs/Miss/Ms): ______________________________

Surname: ______________________________

Forename: ______________________________

Address: ______________________________

EmailL ______________________________

Daytime Telephone No: ______________________________

Evening Telephone No: ______________________________

Date of Birth: ______________________________

Occupation: ______________________________

Certain medical conditions can affect dental treatment and vice versa.
Please complete this form by ticking the appropriate boxes and answering the questions.

All details will be strictly confidential.

Do you or have you ever suffered from:	YES	NO
Rheumatic fever?		
Any heart complain, heart surgery or stroke?		
Diabetes?		
Epilepsy or fainting attacks?		
Chronic bronchitis or asthma?		
Hepatitis?		
Excessive bleeding?		
High blood pressure?		
Any other serious illness?		
Do you carry a medical warning card?		
Are you allergic to any medicine, tablets, substances or latex? (list below in notes)		
Are you at present taking any medicine or tablets? (list below in notes)		
Are you pregnant?		
In the past two years have you undergone any operations?		
In the past two years have you been treated with hydro-cortisone or corticosteroids?		
Have you ever had a joint replacement operations?		
Please tick or **tell the dentist** if you are HIV positive?		

If you smoke, what is your average per week? ______________________________

What is your average weekly consumption of alcohol? ______________________________

Thanet House Dental Care
Thanet House
65, Thanet Road,
Bexley, Kent, DA5 1AP
Tel: 01322 558548
Email: reception@thanethousedental.co.uk
Website: www.thanethousedental.co.uk s

If "yes" to any of these questions please supply details in "Notes" below:

Name and address of your Doctor: ____________________ Notes: ____________________

If you are not sure of any of the questions or if your medical circumstances change, please inform the Dental Surgeon

Patient Signature: ______________________________ Date: ______________

Emergency Contact Details:

Telephone Number ____________________
Persons Name ____________________
Relationship to Patient ____________________

Date of Review	Changes Advised	Patient's Signature
Any changes? Yes ☐ No ☐		Dentist's Signature

Date of Review	Changes Advised	Patient's Signature
Any changes? Yes ☐ No ☐		Dentist's Signature

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