Quarry Rise
Dental Centre

Call: (020) 8642-3739

Private Patient

Confidential Registration and Medical History Form

Title: _________________ Forenames: ______________________ Surname: ____________________________

Address:____

____ Post Code: __________________

Date of Birth: __________________ email: ____

Home Telephone: ______________________ Mobile: ______________________ Work: ______________________

Male/Female Occupation: ____________________________ Last dentist visit?___________________________

Doctor's Name and Address: ____

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How would you describe your general health? Excellent, good, fair or poor? ________________________________

Do you have a preferred dentist?____

How did you hear about us? ____

Medical history

Are you currently?	Yes	No	Give details
Pregnant?			
Receiving treatment from a doctor?			
Taking any prescribed medicines (eg tablets, ointments, injections, inhalers, contraceptive pill, hormone replacement therapy)?			
Carrying a medical warning card?			

Do you/have you ever suffered from	Yes	No	Give details
Rheumatic Fever			
Heart Trouble			
Heart Murmur			
Pacemaker Fitted			
Artificial heart valve			
Abnormal blood			
Epilepsy			
Fainting or blackouts			
Lung disorders			
Hepatitis			
Kidney Trouble			
Diabetes			
Blood Pressure or stroke			
Blood disorders (list) including Anaemia			

Are you allergic to or react badly to any of the following	Yes	No	Give details
Local Anaesthetic			
Penicillin			
Other medicine			

Signature of patient: ___________________________________Date: ______________ (parent or guardian to sign for minors)