CONFIDENTIAL MEDICAL HISTORY

This confidential information will help us prepare for your visits with us. Any information provided will be treated in the strictest confidence. No medical problems or infections will exclude you from essential treatment.

TITLE ..... FULL NAME .....

PREFERRED NAME…… DATE OF BIRTH ..... SEX: MALE ☐ FEMALE ☐

OCCUPATION ..... HOME ADDRESS …….....……

..... E-MAIL.....……...

TEL.NO: HOME ..... WORK ..... MOBILE..……..…..…….……

WORK ADDRESS ……..…

WHICH NO. AND WHEN IS THE BEST TIME TO CONTACT YOU ……...……

YOUR DOCTOR'S NAME & ADDRESS … .....……..……

.....……..... Tel. .....……..

WHEN WAS THE LAST TIME YOU RECEIVED REGULAR DENTAL CARE? …….....……

PREVIOUS DENTIST DETAILS …….....

……..……

WHAT WOULD BE YOUR PERFECT DENTAL PRACTICE? .....……..…

……...……...

OTHER FAMILY MEMBERS SEEN BY US ……...….

REASON FOR YOUR VISIT TO US? ……...

HOW DID YOU HEAR ABOUT THE PRACTICE?
Recommended ..... *Advertisement* ..... *Internet*…… *Other* .....
(If recommended whom may we thank for referring you? ……..)

ARE YOU NERVOUS ABOUT DENTAL TREATMENT? …….....…
If yes, is your Dental comfort level *LOW* ☐ *MEDIUM* ☐ *HIGH* ☐

DO YOU BELONG TO A PRIVATE MEDICAL OR DENTAL INSURANCE SCHEME? .....…..……

Please tick either	**YES**	or **NO**	**FURTHER DETAILS**
ARE YOU:			
1) Attending or receiving treatment from a doctor	☐	☐	_____
2) Taking any medicine, skin creams, pills, ointments or other drugs	☐	☐	_____
3) Taking or have taken steroids in the last 2 years	☐	☐	_____
4) Allergic to or ever had any unfavourable reaction to penicillin or any other drug or substance eg. Latex, Iodine, Food (like bananas, bell pepper, avocado, Kiwi, nuts)	☐	☐	_____

Please turn over →

Montrose Smile Studio
2 Montrose Avenue, Whitton, Twickenham, Middlesex TW2 6HB
020 8894 4639 www.montrosesmilestudio.com

Please tick either	YES	NO	FURTHER DETAILS
HAVE YOU:			
1) Had Rheumatic Fever or chorea (St.Vitus' dance)	☐	☐	
2) Ever been told you have a heart murmur or a heart problem (eg.angina, blood pressure or heart attack)	☐	☐	
3) Had a heart pacemaker or have had any heart surgery	☐	☐	
4) Had any chest trouble including infection eg.bronchitis, tuberculosis or pneumonia	☐	☐	
5) Had jaundice, liver or kidney disease	☐	☐	
6) Had your blood refused by Transfusion Services	☐	☐	
7) Had severe bleeding that needed special treatment after extraction, surgery or injury	☐	☐	
8) Had a joint replacement	☐	☐	
9) Had any serious illnesses or operations requiring hospitalisation	☐	☐	
10)Ever had an adverse reaction to local or general anaesthesia	☐	☐	
11) Come into contact with anybody who has HIV or suspected AIDS	☐	☐	
12) Have you / your immediate family had COVID-19	☐	☐	
13) Have you had COVID vaccine	☐	☐	
DO YOU:			
1) Suffer from hay fever, eczema, asthma or any other allergy	☐	☐	
2) Get fainting attacks, giddiness, blackouts or epilepsy	☐	☐	
3) Have diabetes or does anyone in your family	☐	☐	
4) Suffer from depressive illnesses	☐	☐	
5) Suffer from severe or frequent headaches	☐	☐	
6) Bruise easily after an extraction	☐	☐	
7) Have any blood disorders (eg.anaemia, leukaemia or haemophilia)	☐	☐	
8) Have arthritis	☐	☐	
9) Smoke? How much	☐	☐	
10) Drink? How much	☐	☐	
11) Get cold sores	☐	☐	
12) Do you exercise regularly	☐	☐	
WOMEN ONLY			
12) Take any birth control pills	☐	☐	
11) Are you likely to be pregnant If yes when is the baby expected?	☐	☐	
12) Are you a nursing mother?	☐	☐	

Are there any other aspects concerning your health that you think the dentist should know about? ……...

Please indicate below if we have your permission for the following:

To take dental photographs for communication, educational or promotional purposes. Yes ☐ No ☐

GDPR: We may contact you from time to time making you aware of special offers that could be of interest to you.

Yes ☐ No ☐

IT IS IMPORTANT THAT YOU INFORM THE PRACTICE IF ANY OF THE ANSWER TO THE ABOVE QUESTIONS CHANGE IN THE FUTURE.

I understand that the responsibility for payment for all professional services provided in this practice for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made and signed by me. In the unlikely event of us needing to recover any sums owed by way of court proceedings, any claim will include a claim for interest, collection and legal costs.

All past due amounts are assessed at 2% per month.

Completed by: Self / Guardian Signature ……..…..….. Date ……..……

Please note that failed or late cancelled appointments (i.e. within 48 hours) are charged for.

Montrose Smile Studio

2 Montrose Avenue, Whitton, Twickenham, Middlesex TW2 6HB

020 8894 4639 www.montrosesmilestudio.com

Please download the completed form and email it to info@montrosesmilestudio.com. Alternatively, you may print the form and drop it off at our practice.