Confidential Medical History Form

Welcome to Smile Dental Care, in order to help us meet all of your dental health care needs, please complete the following confidential medical history form. Please ask a member of our team if you need any further assistance or have any questions.

Private Patient Registration Form

Title: MR **Full Name:** OVIDIU PAUL LAZAR **Date Of Birth:** 02 MAY 1985

Address: 13 MALLARD DRIVE **Post Code:** SL1 5BW

Mobile: 07802-490339 **Email:** lazar_paul_2006@yahoo.com

Occupation: CUSTOMER SERVICE **GP Doctor/Surgery:** SHREEJI MEDICAL CENTRE

Emergency Contact: (Name) DANIELA RUS **(Contact Number)** 07525 408 447

PLEASE TICK THE APPROPRIATE BOXES	Yes	No	Notes:
Are you receiving any **treatment** from a doctor, hospital or clinic?		X	
Are you carrying a **medical warning card**?		X	
(Ladies Only) Are you **pregnant** or possibly pregnant?		X	
Do you have **allergies** to medicines, substances or foods (e.g. penicillin/amoxicillin)?		X	
Do you have any **chest conditions** e.g. bronchitis, asthma?		X	
Do you have fainting attacks, giddiness, blackouts or **epilepsy**?		X	
Heart problems/surgery e.g. Angina, blood pressure problems, stroke, pacemaker?		X	
Do you have **diabetes**? (Does anyone in your family?)		X	
Do you have **bone or joint disease**?		X	
Bruising/persistent bleeding following injury or tooth extraction?		X	
Do you have **liver disease** (jaundice, hepatitis)/**kidney disease**?		X	
Do you have any other **serious illness or infectious disease**?		X	
Any form of **mental illness** (e.g. depression, anxiety, stress, eating disorders	X		ANXIETY
Blood refused by the blood transfusion service?		X	
Have you had a bad reaction to a **general or local anaesthetic**?		X	
Do you **smoke/take tobacco**?	X		
Do you drink **alcohol**? (If so, how many units per week?)	X		4 BEERS ON A FRIDAY
Any you taking any **prescribed medicines** (e.g. tablets, injections, or inhalers), including contraceptive or hormone replacement therapy?	X		SERTRALINE 50MG
Please note any other details			

Cancellation & Missed Appointments: should you need to change your appointment time or date, we simply ask for at least 24 hours' notice. Multiple late or missed appointments may result in you being unable to be seen at our practice.

Do you smoke? (Yes) ☐ No ☐ In the past

Would you prefer us to contact you with special offers that we believe may be of interest to you? Yes (No)

How can we help you improve your smile?

☐ Stained/discoloured teeth ☐ Missing teeth
☒ Unsightly fillings
☐ Uneven teeth
☐ Bad breath

Other:

Do you have private medical/dental insurance?

No **Yes, please specify:** HEALTH SHIELD

Patient/Parent/ Guardian Signature: **Date:** 25/08/2021