FERRY DENTAL CENTRE

We appreciate your selection of our Practice to serve your dental health needs. Our goal is to provide you the very best possible dental care. Please provide us with the following information so that we may get to know you better.

PERSONAL DETAILS

First name:	Surname:	DOB: DD / MM / YYYY
Occupation:	Title (please circle) Mr Mrs Ms Miss	
Previous dentist:	Date of last dental exam:	

Home Address:	Postcode:
Email:	home telephone:
Mobile telephone:	Next of kin name and contact:
GP details name and address	

How did you hear about us?

Word of mouth ☐ (please state name of referee)
Google search ☐ (please provide what words you used ie 'dentist southampton')
Other ☐ (please provide details)

By signing this form you consent that we may take intra oral clinical images for the purposes of: assessment, diagnosis, treatment planning, education and outcome. These images may also be used in printed and digital media in the format of "Before and After". Your identity will always be protected and we will contact you for your consent before publishing.

Reason for appointment:	
Are you satisfied with the appearance of your smile?	
If you could change anything about your smile, what would it be?	

Is there anything else you would like to share with us today:

If you are filling this Medical History for someone else, what is your name and relationship?	NAME RELATIONSHIP

By **providing** your **email** address, you consent that we may email you confidential and sensitive information related to your **dental treatment** (treatment plan, x-rays, photographs, etc), your **accounts** (payments made, future appointments, etc), relevant to you **content** (how to take care of your new filling, how to keep your teeth white, etc). We make every effort to ensure the security and integrity of emails but no transmission over the internet is guaranteed to be 100% secure. **We will never share your details** with anyone else, unless necessary (e.g. referrals).

Please turn over for the MEDICAL HISTORY

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Please circle			Please provide more details
NO	YES	Are you currently pregnant? (if yes, how far along and/or due date)	
NO	YES	Are you currently receiving treatment from a doctor, hospital or clinic?	
NO	YES	Are you currently taking any prescribed medicines? (eg tablets, ointments or inhalers, including contraceptives and hormone replacement therapy)	
NO	YES	Are you carrying a medical warning card? (if yes, what for)	
NO	YES	Do you or those living in your household have COVID-19 symptoms? (new, persistent cough or high temperature or anosmia (change or loss of smell or taste)	
NO	YES	Are you classed as a vulnerable or shielded person?	

NO	YES	Do you suffer from any allergies ☐medicines ☐penicillin ☐latex/rubber ☐foods ☐other	
NO	YES	Do you suffer from: ☐hay fever ☐eczema	
NO	YES	Do you suffer from: ☐bronchitis ☐asthma ☐other chest condition	
NO	YES	Do you suffer from: ☐fainting attacks ☐giddiness ☐black outs ☐epilepsy	
NO	YES	Do you suffer from: ☐heart problems ☐angina ☐blood pressure ☐stroke	
NO	YES	Are you diabetic: ☐type I ☐type II ☐family member	
NO	YES	Do you suffer from arthritis?	
NO	YES	Do you suffer from: ☐bruising ☐persistent bleeding following ☐injury ☐tooth extraction ☐surgery	
NO	YES	Do you suffer from any infectious diseases including ☐HIV or ☐hepatitis	
NO	YES	Have you ever had: ☐rheumatic fever ☐chorea	
NO	YES	Have you ever had: ☐liver disease ☐jaundice ☐hepatitis ☐kidney disease	
NO	YES	Have you ever had any other serious illnesses?	

NO	YES	Have you ever had blood refused by the Blood Transfusion Service?	
NO	YES	Have you ever had a bad reaction to ☐general ☐local anaesthetic?	
NO	YES	Have you ever had a joint replacement or other implant?	
NO	YES	Have you ever had treatment that required you to be in the hospital? Please provide details and dates.	
NO	YES	Have you ever had heart surgery?	
NO	YES	Have you ever had brain surgery?	

NO	YES	Did you receive growth hormone therapy before the mid 1980's?	
NO	YES	Do you have any close relatives (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob disease?	

NO	YES	Do you regularly drink more than 14 units of alcohol per week? 1 unit = half a pint = 25 ml spirit = small glass of wine (50ml)	
NO	YES	Do you smoke any tobacco products ☐now ☐in the past ☐vape	
NO	YES	Do you chew tobacco, pan, use gutkha or supari ☐now ☐in the past	

Is there any other medical information which your dentist might need to know about, such as self-prescribed medicines (eg aspirin, herbal supplements, etc) or anything else related to your general health.	

DATE: DD / MM / YYYY	SIGNATURE: if submitting by e-mail, write your initials.

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