# CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Patient

Date



Welcome to Affinity Dental Care & Implant Centre, in order to help us meet all of your dental healthcare needs, please complete the following medical and dental history form. Please ask a member of our team if you need any assistance or have any questions.

PERSO	NAL DETAILS			
Title Mr	Mrs Miss Ms Other			
First name		Date of birth	Home tel.	
Surname		Occupation	Mobile tel.	
Address		\	Postcode	
Email addr	ess			
Text Email Please tick <b>one</b> preferred method of contact / reminder.				
Please upda	te us with changes to email address or phone numbers.			
GP'S DI	ΕΤΔΙΙ S			
Name				
Address				
MEDICAL HISTORY – <b>Do you have</b> or <b>have you had</b> any of the following?				
	nform us of any medical conditions, past/present/penc		our dental care	
	space over if required.	ing and medication(s) as it could affect y	our dentar care.	
YES NO		YES NO		
	Heart condition including heart attack / heart murr / angina?	nur Do you have any a	allergies to any medicine / tablets / latex?	
	Diabetes?			
	Epilepsy?		prescribed or self prescribed meopathic remedies?	
	Chronic bronchitis / asthma / hayfever?	Cgirispii ii iici	neopatino remetiles.	
	Hepatitis?			
	Rheumatic fever?			
	Excessive bleeding or bruising?			
	High or low blood pressure?	Any other serious	illness (eg stroke / cancer / surgery)?	
	Are you or do you think you may be HIV positive?	Any other serious	Timess (eg stroke / dander / surgery).	
	Do you have any artificial joints?			
	Do you smoke? If yes, how many per day?	Women only;		
	Have you been treated with either hydrocortisone or corticosteroids in the last two years?	Are you pregnant	?	
			aby in the last year?	
_				
	at I have read and understood the above questions an $oldsymbol{a}$ can be dangerous to my health and I will inform my		I understand that any incorrect	

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Any other medical information?



### DENTAL HISTORY – Do you have...

YES NO

Pain or discomfort in your teeth?

Sensitivity in your teeth?

Bleeding when brushing / flossing?

YES NO

Unpleasant taste / odour in your mouth?

Food often stuck between your teeth?

Suffer from mouth ulcers / cold sores?

#### HOW DO YOU RATE YOUR SMILE?



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#### MEMBERSHIP PLANS & FINANCE OPTIONS

If you are already not a member would you like to know more about Affinity Dental Care & Implant Centre range of membership plans that may save you money and assist with budgeting? These include special rates for children. Additionally, we can offer 0% finance (subject to status) on new treatment plans, please ask for details.

YES NO

#### HOW DID YOU HEAR ABOUT US

#### DATA PROTECTION

In order to provide you with a high standard of dental care and attention, we need to hold personal information about you. At Affinity Dental Care & Implant Centre there may be occasions where a relative/spouse/partner or person may request information from us. Due to data protection we are not permitted to give out any information requested without your permission.

Please inform us if you are happy for us to discuss your personal information; such as your appointments with a person of your choice. There may also be occasions where it would be beneficial to discuss such information with your appointed person if we are unable to get in touch with you.

Appointed Representative

#### **SIGNATURE**

#### Cancellation and missed appointment policy

A minimum of 24 hours notice for any changes to your appointments is required. Missed or failed appointments mean that other patients cannot be seen and lead to higher charges. To reduce this Affinity Dental Care & Implant Centre have a strict policy of charging for missed or failed appointments. We may also request a deposit for long appointments. It is the practice policy to charge our patients a fee for any missed / late cancelled appointments to cover the practice operating expenses. The fee charged is £90 per hour and is based on the length of the appointment missed.

I understand the Affinity Dental Care & Implant Centre's cancellation and missed appointment policy. I agree to be responsible for the payment in full of all services rendered on my behalf.

X

Date

Affinity Dental Care & Implant Centre

Date

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**Patient** 

AffinityImplant



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