MIRIAM GROVES
DENTAL

Patient Introduction Form – Details and Medical History

It is important to know details about your medical history as these could affect clinical decisions and outcomes, as well as your safety.

Please note that all information on this form will remain strictly confidential.

Title _____Given name(s)_____ Surname_____

Address _____

Phone: (H)_____ (W)_____ (Mobile)_____

Date of Birth ____/____/_____ Do any other family members attend here?_____

Email (not used for advertising)_____

Occupation _____(Or previous if retired _____)

Your family doctor _____ Referred here by _____

Emergency contact: name and phone number _____

Are you in a Health Fund for Dental Treatment? Please circle: Yes / No

Would you like an SMS or email reminder for your appointments? Pls circle: Text / Email

Dental history

Please tick if any of the following are causing you concern:

Sensitivity		Painful joints		Bleeding gums		Discoloured teeth	
Rough fillings		Grinding		Bad breath		Your smile ☺	

Have you ever had an adverse reaction to dental treatment or local anaesthetic? _____

What is the main purpose of your visit today? _____

How long since your last dental visit? _____ Have you had orthodontic treatment? _____

Have you had any significant dental treatment/surgery? _____

Continued over….

Medical history: Have you *ever* had any of the following? *Please write YES or NO for each*:

Heart disorder		Cardiac pacemaker		Hepatitis or liver disease	
Kidney disease		Stroke		Excessive bleeding	
Prosthetic implant		Asthma		High blood pressure	
Diabetes		Cancer		Digestive condition	
Rheumatic fever		Epilepsy		Eating disorder	
Depression		Anxiety		Other Mental Illness	
Osteoporosis		HIV positive test		Allergy to Medications	
Lung disease		Radiation therapy		Allergy to Penicillin	
Sleep apnoea		Are you pregnant?		Allergy to Latex	
Thyroid dysfunction		Reflux		Allergy to Casein Protein/Milk	

Any other medical conditions? _____

Have you been in hospital during the past two years? _____

Please list all medications or recreational drugs you are taking here_____

_____

Do you smoke, or have you been a smoker?_____ If quit, how long ago? _____

Do you play sport?_____ What type? _____

Consent

I consent to the performing of dental and oral surgery procedures agreed to be advisable, including the use of local anaesthesia if required and I assume responsibility for the cost.

I understand that *all* medical procedures, including administering local anaesthesia, carry an inherent risk, albeit small. I understand the clinician will advise me of the details of these risks for high risk procedures only.

I consent to the practice using photograph of only my teeth/smile for social media purposes.
Please circle Yes / No

I understand there is a cancellation fee if reasonable notice is not given, or for failure to attend an appointment. An administration fee is payable if service is not paid for on the day of treatment. (Accounts are only issued in exceptional circumstances)

Patient/parent/carer signature _____Date_____

Follow us on instagram: miriam_groves_dental & Facebook Miriam Groves Dental for details of exceptional opening hours, updates and to stay connected with us ☺