ashford
DENTAL CARE

it all starts with a smile...

CONFIDENTIAL MEDICAL HISTORY FORM

To obtain the best and safest treatment your dentist needs to know of any medical problems which may affect your childs treatment.

Title: **Full Name:**	
Date of Birth: **Sex: Male / Female** **Mobile No:**	
Address:	
Postcode:	
Tel No: Home: **Email:**	
Your Doctors Name & Address:	
Your Dentists Name & Address	
How did you here about us:	

Please complete for your child:	**Yes**	**No**	**Details**
Attending or receiving treatment from a Doctor, Hospital, or specialist for any medical care:			
Taking any medicines from your Doctor, (tablets, ointments, injections, inhalers)Please include amount, dosage and timings.			
Taking or have you taken steroids in the last two years			
Allergic to any medicines, foods or materials in particular penicillin?			
Have They:			
Had jaundice, liver, kidney disease or hepatitis?			
Ever been told you have a heart murmer or heart problem, Pacemaker or any heart treatment?			
Have you ever been diagnosed with any medical Condition or syndrome?			
Had a bad reaction to a general or local anaesthetic?			
Been in hospitalised? If yes what for and when?			
Do You:			

Ashford Dental Practice
8 New Rents Ashford Kent TN23 1JJ
T 01233 639289 F 0870 383 6481
www.ashforddental.co.uk
info@ashforddental.co.uk

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	Yes	No	
Believe your child is in good health? If no give details			
Have arthritis?			
Suffer from hayfever, eczema or any other allergy?			
Suffer from bronchitis, asthma or other chest condition ? and who are you under the care of?			
Have fainting attacks, giddiness, blackouts or epilepsy? What treatment do they currently have or may potentially need?			
Carry a warning card?			
Are there any other aspects concerning your health That you think we should know about?			
Signature:			
Date:			

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