Bourne Hall Dental Practice

Dr. S. Dattani BDS   *Dr. J. Patel BDS*

1st Floor, Bourne Hall Medical Centre, Chessington Road, Ewell, Surrey, KT17 1TG 0208 394 2154 / 1614

This provides the dentist with important information required for your dental treatment and oral health care. Please complete in **BLACK INK ONLY**

Dr/Mr/Mrs/Miss/Ms/Mst **NAME** ____________________ **D.O.B** __________

Home Address: ____________________ Work Address: ____________________

____________________ ____________________

____________________ ____________________

Home Phone: ____________________ Work Phone: ____________________

Occupation: ____________________ E-mail: ____________________

Details of person to contact in an emergency:

Name: ____________________ Phone Number: ____________________

Medical Doctors Name: ____________________ Phone Number: ____________________

MEDICAL HISTORY

Have you ever had any of the following? If so, please tick as appropriate:

- ☐ Rheumatic Fever or Chorea
- ☐ Heart Trouble
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Bronchitis or Chest Problems
- ☐ Gastric Problems
- ☐ Hepatitis - Specify type A, B, C
- ☐ Kidney Trouble
- ☐ Arthritis
- ☐ Multiple Sclerosis
- ☐ Anaemia
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Severe Headaches, faints or dizziness
- ☐ Depressive Illness
- ☐ Drug Dependence or addictions

Please tick as appropriate	Yes	No
1. Are you receiving any medical treatment at the present time? Details: ____________________		
2. Have you been a patient in hospital or under the care of a doctor during the past two years? Reason: ____________________		
3. Have you taken any medicine tablets, capsules or drugs during the past two years? ____________________		
PLEASE CONTINUE ON THE BACK OF THIS FORM 4. Have you ever experienced any allergies or unusual effects from any tablets, drugs, injections or anaesthetic? Details: ____________________		
5. Have you had any prosthetic surgery? (e.g. Heart Valve or Hip Replacement) Details: ____________________		
6. If female, are you pregnant? If so, how many months? __________		
7. Do you have any blood borne diseases or CJD? ____________________		
8. If you are a smoker, how many cigarettes do you smoke per day?__________		
9. How many units of alcohol do you drink per week? (2units = pint of beer, 10 units = bottle of wine) _______		

DENTAL HISTORY

1. Name of last dentist: ____________________
2. Approximate date of last dental visit:____________________
3. Do you have Dental pain or a Dental problem at present?
   Details: ____________________

4. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches?		
5. Do you become anxious or uncomfortable when you are having dental treatment?		
6. Do you have dental treatment under sedation?		

REFERRED BY:

- ☐ Yellow Pages
- ☐ Street Sign
- ☐ Another patient (Name) ____________________
- ☐ Other (please specify) ____________________

Signed: Patient/Parent/Guardian ____________________ **Date:** __________