Wallasey
ORTHODONTICS

Information

Patient Information

Name ………………………………………….
Date of Birth ………………………………………….
Address ………………………………………….
Postcode ………………………………………….
Email ………………………………………….

Contact information

Phone ………………………………………….
Mobile ………………………………………….
Next of Kin ………………………………………….
Parent/Guardian …………………………….
Best time to call …………………………….

Dentist

Name ………………………………………….
Practice ………………………………………….

Doctor

Name ………………………………………….
Practice ………………………………………….

Medical History

Have you ever suffered from the following?

Condition

Condition	Y	N
Asthma	Y………	N………
Diabetes	Y………	N………
Bleeding	Y………	N………
Heart	Y………	N………
Chest	Y………	N………
HIV/AIDs	Y………	N………
Epilepsy	Y………	N………
Migraine	Y………	N………
Hepatitis	Y………	N………
Jaundice	Y………	N………
Rheumatic fever	Y………	N………

Do you have any allergies? Please state ……………………………………………………………………….

Are you likely to be pregnant? ……………………………………………………………………….

Are you prone to fainting? ……………………………………………………………………….

Have you ever been hospitalised? ……………………………………………………………………….

Are you undergoing medical treatment? ……………………………………………………………………….

Are you taking medication? What's it for? ……………………………………………………………………….

Please list medication taken ……………………………………………………………………….

Do you have any communication needs? ……………………………………………………………………….

Best way to contact you? Mobile/Post/Email ……………………………………………………………………

Do you, or have you ever smoked tobacco products? If so how many a day? ……………………….

Do you, or have you ever chewed tobacco? ……………………………………….

Do you drink alcohol? How many units a week? ……………………………………….

Any other medical information you think we should know? ……………………………………….

Have you had any injury to your teeth? ……………………………………….
Have you been to see an orthodontist before? ……………………………………….

Print name …………………………………………. Date ………………………………………….

Signed name ………………………………………….

Relationship ………………………………………….