Holistic Dental Care
Ravenscourt
Dental Practice
Dr H Batavia & Associates

Confidential Medical History Form

PATIENT INFORMATION

Title: Miss ☐ Mrs ☐ Ms ☐ Mr ☐ Dr ☐ other ☐ *(please specify):* _____

Surname: _____ **First Name:** _____ **D.O.B:** __ __ / __ __ / __ __ __ __

How did you hear about us? _____

Address: _____ **Work tel:** _____

_____ **Home tel:** _____

_____ **Mobile tel:** _____

Postcode: _____ **Email:** _____

Occupation: _____ **Last dental visit?** __ __ / __ __ / __ __ __ __

Your Doctor (GP) details: _____

YOUR HEALTH	Yes	No
Are you pregnant?		
Are you receiving any form of treatment from a doctor, specialist, hospital or clinic?		
Have you ever been hospitalised or had surgery?		
Are you taking any prescribed medication? (e.g. tablets, creams, inhalers, injections, contraceptives, cancer medication, bone density medication or HRT)		
Are you allergic to any medicine or materials?		
If YES, do you carry a warning card?		
Do you have bronchitis, asthma or any other chest conditions?		
Do you have angina or high/low blood pressure?		
Do you have hay fever, eczema or any other allergy?		
Do you have fainting attacks, giddiness, blackouts or epilepsy?		
Do you or anyone in your immediate family have diabetes?		
Do you bruise easily or bleed excessively?		
Are you receiving any complementary therapy?		
Have you ever smoked or used tobacco products in the past?		

020 8748 4023
team@rdpholistic.co.uk | www.rdpholistic.co.uk
Ravenscourt Dental Practice @RDP_Dentist

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YOUR HEALTH HISTORY	Yes	No
Have you ever had rheumatic fever or chorea (St.Vitus dance)?		
Have you ever had a heart attack?		
Have you ever had heart surgery or pacemaker fitted?		
Have you ever had a stroke?		
Have you ever had jaundice, hepatitis, Liver or kidney disease?		
Have you ever had a joint replacement or other implant?		
Have you ever had a bad reaction to general or local anaesthetic?		
Have you taken steroids in the last two years?		
Are there any other aspects about your health you think the dentist should know about?		

DENTAL HISTORY	Yes	No
Do you use anything to clean in between your teeth?		
Do your gums bleed?		
Are you aware if you grind or clench your teeth?		
Do you suffer from head, neck or shoulder pains?		
Do you or have you ever suffered from clicking jaw joints?		
Are you happy with the appearance of your teeth?		
Do you have a preference for a tooth coloured filling on the biting surface of your back teeth?		
Do you suffer from any recurrent dental/oral problems?		
Do you have any particular anxieties with dental treatment, for example drilling, injections?		

Do you suffer from any of the following:
Mouth ulcers Yes ☐ No ☐ Cold sores Yes ☐ No ☐ Dry mouth Yes ☐ No ☐

Do you take sugar with?
Tea Yes ☐ No ☐ Coffee Yes ☐ No ☐ Cereal Yes ☐ No ☐
If yes how often and how much?

How often you drink fizzy or fruit concentrate drinks?

Tick how often you eat sweets/sugary snacks and what snacks you eat?
Before meals Yes ☐ No ☐ After meals Yes ☐ No ☐ between meals Yes ☐ No ☐
Chocolate ☐ Yogurt ☐ Cakes ☐ Biscuits ☐

Do you use any of the following:
Electric toothbrush Yes ☐ No ☐ Dental floss Yes ☐ No ☐ Disclosing solutions Yes ☐ No ☐
Mouth/gum rinses Yes ☐ No ☐ Interdental products Yes ☐ No ☐

How long would you like to keep your teeth?
As long as possible Yes ☐ No ☐ For a few years Yes ☐ No ☐ Not bothered Yes ☐ No ☐

When did you last attend the dentist and what did you have done?

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MEDICAL UPDATE *(Any health changes)*

Any changes/further information: _____

Date: __ __ /__ __ /__ __ __ __ Patient Initials: _____

AUTHORISATION

Consent for Clinical Photography

I consent to having clinical photographs taken for the purpose of treatment diagnosis and results. These will be kept absolutely confidentially and securely and will only be used in ways that I have given consent for. I understand that I will be recognisable in the photographs but that no personal details will be visible.

I expressly authorise my photographs to be used for the following purposes:

To be stored securely on a digital device for the purpose of my confidential clinical records	Yes ☐ No ☐
To be used internally at the practice to show patients our high standards of treatment and the results that we achieve	Yes ☐ No ☐

Communications Consent Form

We process personal data for the purpose of providing optimum healthcare, sending important updates to you, providing you with news about treatments and what is happening at the practice and informing you about our services and promotions.

For marketing communications (including important practice announcements, updates & news of practice services, promotional offers & other marketing news and information)	Yes ☐ No ☐
The practice can contact me by email	Yes ☐ No ☐

You can withdraw your consent at any time by email to **team@rdpholistic.co.uk** or by writing to **Ravenscourt Dental Practice, 5 Ravenscourt Avenue, London W6 0SL**.

Print Name: _____ **Signature:** _____ **Date:** __ __ /__ __ /__ __ __ __