ADC™
CENTRE FOR RESTORATIVE AND IMPLANT DENTISTRY

NEW PATIENT DENTAL HISTORY FORM

Please note that all information on this medical/dental form will remain strictly confidential. Please complete in **CAPITAL LETTERS.**

Surname		Name	Mr. /Mrs./Ms
Date of Birth		Occupation	
Phone (H) Phone (W) Phone (Mobile)	(Please tick the number that you prefer we contact you on)	Home Address Postcode	
Email address			
Emergency contact (please provide name and phone number):			

Have you ever had any of the following? Please tick those that apply:

☐ Anemia	☐ Excessive Bleeding	☐ High Blood Pressure
☐ Artificial joints	☐ Diabetes	☐ Kidney Disease
☐ Asthma /Respiratory problem	☐ Heart Disease	☐ Liver disease
☐ Blood Disease	☐ Rheumatic fever	☐ Tuberculosis
☐ Epilepsy	☐ Hepatitis/HIV: AIDS	☐ Fainting
Are you pregnant? If yes, how many months?		

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Do you have any allergies to Penicillin or other drugs? If yes, Please provide more information	
Is your blood pressure normal, High or low?	
Do you smoke? If so how many per day?	

DENTAL HISTORY

- **Are you concerned about or experiencing any of the following dental problems? (Please tick as many as it applies)**

- ☐ Sensitivity to hot or cold
- ☐ Clicking/pain in the jaw joint
- ☐ Discolored fillings
- ☐ Bleeding gums
- ☐ Sensitivity when eating
- ☐ Food trapping between your teeth
- ☐ Staining of your teeth
- ☐ Roughness of existing fillings
- ☐ Bad breath
- ☐ Grinding or clenching of your teeth

- **Are you concerned with: (please tick as many as it applies)**

- ☐ Existing crowns, bridges or dentures
- ☐ Gaps between your teeth
- ☐ Your smile
- ☐ Crooked teeth
- ☐ Silver fillings
- ☐ Ability to eat
- ☐ Tooth clean techniques (e.g.Brushing /Flossing)
- ☐ Discoloration of your teeth
- ☐ Missing teeth
- ☐ Previous dental treatment

What is the main purpose of your visit today?

_____

How long since your last dental visit?

_____

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Does dental treatment make you nervous?

☐ No ☐ Slightly ☐ Moderately ☐ Extremely

CONSENT FOR SERVICES

I, the undersigned, consent to the performing of dental and oral s surgery procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated and I will assume responsibility for the fees associated with those procedures. .I hereby consent to the use of any study models, x-rays, computer images and photographs at various dental seminars, lectures, and publications that the dentists may author.

I am aware that payment is required on the day of treatment and I wish to receive promotional, appointment and other intimations from Avance Dental Care.

Signature