ANDERSON &BROADBERRY DENTAL CARE

46 Worksop Road, Swallownest, Sheffield S26 4WD
Tel: 0114 287 2305 www.abdentalcare.co.uk

How did you first find out about the Practice?
website / family or friend / dentist referral / press / word of mouth / NHS Direct / practice sign / other
Please circle

Name		Date of Birth		Male / Female
Address		Mobile No.		
		Home No.		
		Work No.		
		Email Address		
Occupation		How long since your last dental treatment?		
Doctor's Name and Address		Are you a member of a dental insurance scheme e.g. Westfield?		Y / N
		Do you pay for your dental treatment?		Y / N

ARE YOU	Yes	No	Details
An expectant mother?	☐	☐	
Taking any medication? If Yes, please provide details.	☐	☐	
Taking or have taken any steroids in the last 2 years?	☐	☐	
Allergic to any medicines, foods or materials?	☐	☐	
HAVE YOU HAD			
Jaundice, liver or kidney disease or hepatitis?	☐	☐	
Any heart problems, heart murmur, angina, high blood pressure or a heart attack?	☐	☐	
Adverse reaction to either local or general anaesthetic?	☐	☐	
Treatment in hospital? If Yes, what for and when?	☐	☐	
DO YOU			
Suffer from arthritis?	☐	☐	
Have a pacemaker, or had any form of heart surgery?	☐	☐	
Suffer from allergic disorders such as Hay Fever or Eczema?	☐	☐	
Suffer from a respiratory disease such as Bronchitis or Asthma?	☐	☐	
Have epilepsy, fainting attacks, giddiness or blackouts?	☐	☐	
Have diabetes or does anyone in your family?	☐	☐	
Have problems with bleeding following a tooth extraction, surgery or injury, or do you take medication, i.e. Warfarin?	☐	☐	
Carry a warning card?	☐	☐	
Have any other relevant medical information that the dentist should know about, e.g. HIV, Hepatitis A,B,C,D?	☐	☐	
What is your weekly consumption of alcohol (units per week)?			
If you smoke, what is your average consumption per week?			

Patient's Signature		Date	

Please inform your dentist if your medical history has changed since you last completed the above

Updates

Please check that all the information on this form is still correct.
Record the review plus any changes below.

Date of Review	Changes advised	Patient's Signature
Any Changes YES NO		Dentist's Signature

Date of Review	Changes advised	Patient's Signature
Any Changes YES NO		Dentist's Signature

Date of Review	Changes advised	Patient's Signature
Any Changes YES NO		Dentist's Signature

Date of Review	Changes advised	Patient's Signature
Any Changes YES NO		Dentist's Signature

Date of Review	Changes advised	Patient's Signature
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