INFINITY SMILES

# CONFIDENTIAL MEDICAL HISTORY

**(For a child under 16 parent/guardian please complete)**

Patients name:..... DOB: D D M M Y Y Y Y

Address:.....

..... Postcode:.....

Occupation / Parent's Occupation:.....

Tel no: Home: ..... Work: ..... Mob:.....

Email Address:..... @.....

**Name of your Dentist:**.....

Address:.....

..... Postcode:.....

Tel no:.....

**Doctors Name:**.....

Address:.....

..... Postcode:.....

Tel no:.....

School/College: Now ..... Future .....

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## 1) WHERE DID YOU HEAR ABOUT US?

- ☐ Our Website.
- ☐ BT Phone Book.
- ☐ Personal Recommendation
- ☐ Your family dentist.
- ☐ Other (Please Specify).

## 2) ON A SCALE OF 1-10, HOW ANXIOUS ARE YOU ABOUT HAVING ORTHODONTIC TREATMENT?

Please tick one:

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|

## DENTAL HISTORY

Please tick one:

| | | | |
|---|---|---|---|
| 1 | Have you ever experienced any complications following dental treatment e.g excessive bleeding? | YES | NO |
| 2 | Have you ever had any clicking, clenching, grinding or pain in the jaw joints? | YES | NO |
| 3 | Have you ever injured your jaw or face? | YES | NO |
| 4 | Have you had a history of sucking your finger or thumb | YES | NO |
| 5 | Have you had previous Orthodontic treatment or an assessment? | YES | NO |
| | Did they take an x ray? | YES | NO |
| | Where? _____ When? _____ | | |
| 6 | Are you prepared to wear any type of brace? | YES | NO |
| 7 | When did you last have a Dental X-ray taken if at all? _____ | | |

## ARE YOU CURRENTLY:

| | | |
|---|---|---|
| Pregnant? | YES | NO |
| Receiving treatment from a Doctor, hospital or clinic? | YES | NO |
| Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)? | YES | NO |
| Carrying a medical warning card? | YES | NO |
| Smoking and drinking? | YES | NO |

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## DO YOU SUFFER FROM ANY OF THE FOLLOWING:

| | | |
|---|---|---|
| Allergies to any medicines (e.g. penicillin), substances (e.g latex/rubber) or foods? | YES | NO |
| Bronchitis, asthma or other chest conditions? | YES | NO |
| Fainting attacks, giddiness, blackouts epilepsy? | YES | NO |
| Heart problems, angina, blood pressure problems, or stroke? | YES | NO |
| Diabetes (or does anyone in your family)? | YES | NO |
| Arthritis? | YES | NO |
| Hay fever or eczema? | YES | NO |
| Bruising or persistent bleeding following injury, tooth extractionor surgery? | YES | NO |
| Any infectious diseases (including HIV and hepatitis)? | YES | NO |

## DID YOU, AS A CHILD OR SINCE, HAVE ANY OF THE FOLLOWING:

| | | |
|---|---|---|
| Heart surgery? | YES | NO |
| Liver disease (e.g. jaundice, hepatitis) or Kidney Disease? | YES | NO |
| Any other serious illness? | YES | NO |
| Blood refused by the Blood Transfusion Service? | YES | NO |
| A bad reaction to general or Local anaesthetic? | YES | NO |
| A joint replacement or other implant? Treatment that required you to be in hospital? | YES | NO |
| Rheumatic fever or cholera? | YES | NO |
| Does your child have special needs? | YES | NO |

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## DO YOU SUFFER FROM ANY OF THE FOLLOWING:

| | |
|---|---|
| Allergies to any medicines (e.g. penicillin), substances (e.g latex/rubber) or foods? | YES NO |
| Bronchitis, asthma or other chest conditions? | YES NO |
| Fainting attacks, giddiness, blackouts epilepsy? | YES NO |
| Heart problems, angina, blood pressure problems, or stroke? | YES NO |
| Diabetes (or does anyone in your family)? | YES NO |
| Arthritis? | YES NO |
| Hay fever or eczema? | YES NO |
| Bruising or persistent bleeding following injury, tooth extractionor surgery? | YES NO |
| Any infectious diseases (including HIV and hepatitis)? | YES NO |

## DID YOU, AS A CHILD OR SINCE, HAVE ANY OF THE FOLLOWING:

### DRINKING

How many units of alcohol do you drink per week?
(A unit is half a pint of lager, a single measure of spirits or a single glass of wine/aperitif.) ☐ per week

### SMOKING AND CHEWING

Do you smoke any tobacco products now (or did you in the past)? YES NO
☐ per day

Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)? YES NO
☐ per day

### MOUTH CANCER CHECK:

It is our practice policy to routinely screen patients for mouth cancer.

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## PLEASE NOTE: WE CHARGE FOR FAILED APPOINTMENTS

Our policy of charging patients helps us reduce the problem of failed appointments and other patients having to wait longer.

- Failed appointment is a £20 charge.
- Failed long appointment ie 20 minutes is a £50 charge. For patients cancelling appointments a minimum of 24 hours notice is required. When under active orthodontic treatment, you will be required to be responsible for your own appointments to be seen at the Orthodontic Practice every 4 – 12 weeks.
- Retainers will only be fitted on completion of treatment.
- During the course of orthodontic treatment you may be treated by a qualified orthodontic therapist or a student orthodontic therapist
- During the course of treatment the parent may or may not be allowed in surgery depending on preference of the orthodontist you are seeing

## YOU MUST SUSTAIN AND MAINTAIN ORAL HEALTH THROUGHOUT TREATMENT

**1** Please circle who made the decision to seek an orthodontic opinion? **Patient** **Parent** **Family Dentist** **Other**

**2** Did you have any say to whom you were referred? YES NO

**3** Are you currently receiving any dental treatment from your dentist? YES NO

**4** Do you have any teeth which are crowned root filled or painful? YES NO

**5** What is your main concern regarding the appearance of your teeth?

.....

**6** I give consent for photographs to be taken for assessment purposes, and for testimonials to be taken for feedback to your dentist and potentially to go on display in the waiting room or website. YES NO

**7** Do you object to us discussing your treatment plan in our open plan area? If so please inform reception. YES NO

**8** How would you rate the position of your teeth on a ratio of 1-10?
(**1=Good 10=Very Bad** ) Please tick one:

1 2 3 4 5 6 7 8 9 10

## I CONSENT TO ANY ORTHODONTIC TREATMENT THAT MAY BE NECESSARY

Signature:

Relationship to patient:

Date: D D M M Y Y Y Y

If you are prescribed a custom made appliance you can ask us for a statement of manufacture. All of our appliances are made within the UK and conform to the medical directive (93/42/EC).

Please let us know if any of the above details change during treatment.