Medical Form

Welcome to iDental

SURNAME……GIVEN NAME……TITLE……

DATE OF BIRTH…… EMAIL……

ADDRESS ……Postcode……

PHONE: Home……Work……Mobile……

EMERGENCY PERSON……Phone……

How did you hear about iDental?……

Medical History

Have you ever had the following (please circle):

NO	YES	Rheumatic Fever
NO	YES	Heart Murmur or Heart Valve defect
NO	YES	High Blood pressure
NO	YES	Excess Bleeding or bruising
NO	YES	Diabetes
NO	YES	Pacemaker
NO	YES	Ladies, Are you pregnant?
NO	YES	Anti-wrinkle/Botox treatment
NO	YES	Cold Sores

NO	YES	Hip Replacement, *if yes when?*
NO	YES	Asthma
NO	YES	Stroke
NO	YES	Hepatitis
NO	YES	Osteoporosis or Bisphosphonate medicine
NO	YES	Do you Smoke?
NO	YES	Do you develop Keloid Scarring?
NO	YES	Dermal Filler treatment
NO	YES	Skin Cancer

List all your current medications (inc herbal):

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List all allergies (including latex):

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Dental and Skin history

What are your dental or skin concerns? ……

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When was your last dental visit? ……

When were your last dental xrays taken? ……

I have provided accurate information about myself. I understand failure to do so may compromise my health.

Signed……Date……