MEDICAL QUESTIONNAIRE

Please complete the following to enable us to treat you in the best and safest way..

Surname: _____ First Name:_____

Address: _____ Male/Female_____

_____ Preferred contact No._____H/W/M

Post Code:_____ Other:_____H/W/M

Date of Birth:_____ Email:_____

Name of Parent/Guardian: (if under 16)_____

Name of your Medical Practitioner:_____

Name and address of your dentist:_____

Have you ever been to another orthodontic practice YES/NO Name of Practice_____

Has a family member attended this practice for treatment YES/NO Name_____

Please tick if the answer is yes & give details where necessary.

Are you:

1) Attending or receiving treatment from a doctor?_____☐

2) Taking or using any medicine, pills, tablets, inhalers, ointments, injection or another drug._____☐

3) Allergic to or ever had any bad reaction to any medicines, substance or food_____☐

Have you:

1) Had rheumatic fever?_____☐

2) Ever been told you have a heart murmur or heart problem?_____☐

3) Had hepatitis or jaundice?_____☐

Do You:

1) Suffer from hay fever, eczema, asthma or any other allergy?_____☐

2) Have fainting attacks, giddiness, blackouts or epilepsy?_____☐

3) Have diabetes or does anyone in your family? _____☐

4) Consume Alcohol beyond recommended levels or smoke? _____☐

5) Bruise easily or bleed so as to cause you to be worried?_____☐

6) Suffer from cold sores?_____☐

Any other information you feel we should be aware of:

_____

Electronic privacy and using your information

Notice to patients/parents – please indicate Yes or No

Our patient privacy policy is available on request or can be accessed on our website

www.meltonorthodontics.co.uk

Are you happy :

to receive text and email messages from us about your treatment	Yes	No
to receive information e.g appointments, treatment plans,photos by text or email	Yes	No
for us to use your anonymised info, photos or models for research or on the website	Yes	No
to receive info relating to the products and services of the practice by text or email	Yes	No

If you wish to unsubscribe to this service at any time please just let us know

I give consent for Melton Orthodontics to send correspondence to my general dentist. YES/NO

Signature ..... (Pt/Parent) Date .....

NB Should you change your address, telephone number or dentist, please advise Reception immediately.