DIAMOND DENTAL CARE
& IMPLANT CENTRE

Patient Details

Title:

First Name:

Last Name:

Sex:

Date of Birth:

Email Address:

Mobile Phone Number:

Home Phone Number:

Address Line 1:

Address Line 2:

Address Line 3:

State:

Post Code:

Occupation:

Work Phone:

Emergency Contact Name:

Emergency Contact Phone Number:

Emergency Contact Relation: How

How did you hear about us?:

DIAMOND DENTAL CARE
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PATIENT CORONAVIRUS QUESTIONS

No Yes

Are you self-quarantining or have you come into contact with someone with confirmed coronavirus infection within the past 14 days?

Do you have a fever or have you experienced a fever within the past 14 days?

Have you recently experienced respiratory problems, such as a cough or difficulty in breathing within the past 14 days?

Have you, within the past 14 days, travelled to an area with documented Coronavirus transmission?

Have you come into contact with people who have recently had a fever or respiratory problems within the past 14 days?

NATURE OF EMERGENCY QUESTIONS

No Yes

Are you an existing patient?

Do you have the following?

No Yes

Toothache

Broken tooth

Swelling

Where is the pain located?

No Yes

Upper Jaw

Lower Jaw

Left Hand Side

Right Hand Side

Back (molar)

Middle (Pre-molar)

Front (anterior)

Type of pain?

No Yes

Mild

Moderate

Severe

Sensitivity

Cause of Pain?

No Yes

Hot

Cold

Biting

Sweet

Air

Constant pain?

Do you have the following?

No Yes

Swelling

Gum boil

Bad taste in mouth

Taking any pain relief / does it help?

Please list anything else of relevance you think the Dentist should know about

Medical History

HEART

No Yes

Rheumatic Fever

Heart Murmur

High / Low Blood Pressure

Angina

Heart Surgery

Thrombosis

Pacemaker fitted

Other Heart Condition

If you selected yes to any heart conditions, please give details

BLOOD

No Yes

Hepatitis A, B, C, D

Anaemia

H.I.V. / AIDS

Sickle Cell

Abnormal Blood Test

Haemophilia

Blood refused by transfusion service

Other Blood Condition

If you selected yes to any blood conditions, please give details

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ALLERGIES

No Yes

Penicillin

Latex

Hay Fever

Medicine

Anti-tetanus Serum

Plants

Eczema

Food

General Anaesthetic

Aspirin

Local Anaesthetic

Other Allergy

If you selected yes to any allergies, please give details

WARNINGS

No Yes

Do you have a hearing or sight impairment?

Do you have a problem being reclined?

Do you require Antibiotic Cover?

Have you had steroids in the last 2 years?

Do you have bruising or persistent bleeding after injury, surgery, or tooth extraction?

Do you carry a Warning Card?

Are you currently having treatment from a doctor, hospital or clinic?

Have you ever had treatment that required you to be hospitalised?

If you selected yes to warnings above, please give details

CHEST

No Yes

Bronchitis

Emphysema

Cystic Fibrosis

Pneumonia

Pleurisy

Chest Surgery

Asthma

Other Chest Condition

If you selected yes to any chest conditions, please give details

OTHER

No Yes

Liver Disease

Kidney Disease

Diabetes / Family with Diabetes

Epilepsy

Acid Reflux or Eating Disorder

Hiatus Hernia

Bone or Joint Disease / Osteoporosis

Artificial Joint

Fainting Attacks or Blackouts

Giddiness

Any past Serious Illness or Infectious Disease

Cancer / Radiotherapy

Depressive illness

Stroke

Nervous Problems

Tuberculosis

Severe Headaches

Cold Sores

Please give details for anything selected yes above

OTHER CONTINUED

Please list and state doses for any prescribed medicines, tablets, ointments, injections or inhalers (inc. contraceptives and HRT) that you are taking:

LIFESTYLE

How many times a day do you smoke tobacco products?

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

No	Yes	
		Are you or could you be Pregnant?
		Is there anything else your dentist should know?

If you selected yes to anything above, please give details