

Patient Information and Medical history Form

Please, complete this form carefully, the information is a part of the health documentation, it is used for the eventual selection of antibiotics, local anaesthesia or some surgical interventions. This information is protected by medical confidentiality law. Please be assured that the information provided by you will be treated in a strict confidentiality.

Please be informed in advance about all conditions and prices of treatments at DENT MEDICO - we are prepared to answer any and all questions you may have.

Last Name First Name..... Sex..... Date of Birth.....

Street AddressCity State.....

Post Code

Insurance in Czech Republic

E-mail Telephone

Where did you hear about us? Internet Press - which: word of mouth recommendation
other:

Contact number if required (illness of the dentist, need to change your appointment,...)

Please indicate if you suffer from any of the following conditions, how long and since when?:

- Allergies (types)
- Medication intolerance
- Long term use of any medication
- Lung or respiratory tract diseases.....
- Asthma.....
- Heart disease, surgery, cardiac stimulator.....
- High blood pressure
- Jaundice (type)
- Glandular fever.....
- Rheumatic fever
- Diabetes (injection, tablets?)
- Epilepsy (any medication?).....
- HIV.....
- Frequent bleeding (medication?).....

Do you suffer from any other condition which is not listed?:.....

Do you prefer treatment with local anaesthesia?

Do you prefer fewer appointments and more treatments in one visit?

When was your last dental examination?

IMPORTANT - ALL CANCELLATIONS MUST HAVE 48 HRS NOTICE OR THE CANCELLATION FEE WILL APPLY.

I have read and agree with the conditions of treatment, have been advised of scope of treatment, price list and costs and confirm that all information I have given is correct.

Date

Signature