Horfield dentalcare

MEDICAL QUESTIONAIRE:

Please complete this with as much detail as possible

Heart conditions	YES ☐ NO ☐	Asthma	YES ☐ NO ☐
High blood pressure	YES ☐ NO ☐	Chest conditions	YES ☐ NO ☐
Diabetes	YES ☐ NO ☐	Epilepsy/fits/convulsions	YES ☐ NO ☐
Kidney disease	YES ☐ NO ☐	Liver disease	YES ☐ NO ☐
Bleeding tendencies	YES ☐ NO ☐	Sleep apnoea	YES ☐ NO ☐
Other significant medical condition	YES ☐ NO ☐	Pregnant or breast feeding	YES ☐ NO ☐
Blood borne virus	YES ☐ NO ☐	Neurological disorders	YES ☐ NO ☐
Smoker	YES ☐ NO ☐	Recreational drug use	YES ☐ NO ☐
Alcohol	YES ☐ NO ☐	Units of alcohol per week:	

If answered YES to any of the above, please provide more details: _____

_____

_____

_____

Is the patient taking any medications? YES ☐ NO ☐ If YES please list below:_____

_____

_____

_____

Does the patient have any allergies? YES ☐ NO ☐ If YES please specify below:_____

_____

_____

Signature of referrer_____ Date_____

Horfield dentalcare

Implant referral form

Please complete all sections

Referring dentist:	Referring dentist signature:
Practice:	
Practice address:	
	Post code:
Telephone:	

Patient name:		Title:	
Date of birth: / /		Gender:	Male ☐ Female ☐
Address:			
		Post code:	
Home telephone:		Mobile:	

Reason for referral:_____

Treatment required:

Conservation																

Extractions		

Implants		

Other treatment required:_____

Please provide radiographs where available

Are relevant, recent radiographs attached: YES ☐ NO ☐

If no please specify reason:_____

Please send the completed form to the below address

Horfield dental care, 525 Gloucester road, Bristol, BS7 8UG

Tel: 0117 951 3026 Email: info@horfielddentalcare.co.uk Website: www.horfielddentalcare.co.uk