



Patient Details

Preferred Pronouns:	
First Name:	
Last Name:	
Address:	
Date of Birth:	
Mobile Number:	
Email Address:	
Occupation:	

Doctor Name:		Practice:	
Dentist Name:		Practice:	
Emergency Contact:		Contact Number:	
Details:			

Where did you hear about Mint Dental Hygiene?	
Are your teeth sensitive?	
Do your gums bleed?	
Would you like whiter teeth?	
Are you aware of bad breath?	

Medical History - add any details at end or back of form

	Yes / No
Do you have any allergies?	
Do you have a pacemaker, heart murmur, history of Rheumatic fever, angina, had any form of heart surgery or any other heart problem?	
Have you had Jaundice, liver, kidney disease or hepatitis?	
Please tick if you have any blood born viruses including H.I.V. Hep C etc	
Are you attending or receiving treatment from a doctor, hospital, clinic or specialist? Detail at the bottom or reverse.	
Have you had a bad reaction to a local anaesthetic?	
Are you taking any medicines from your doctor? (Tablets, creams, ointments, injection, contraceptive pill, other) Please list at bottom or reverse.	
Have you taken steroids in the last 2 years?	
Have you had a joint replacement?	
Do you carry a warning card?	
Are you diabetic?	
Do you have epilepsy?	
Have you ever had Chemo or Radiotherapy?	
Do you have any other medical condition not mentioned?	
Are you a smoker or vape?	
How many units of alcohol do you consume on average per week? 1/2 pint beer/lager = 1 unit 1 small glass wine = 1 unit	
Are you Pregnant?	
Last Dental Visit?	

Leaving the surgery, any non-payment of treatments will incur additional fees and any cost related to debt collection.

By signing this two page New Patient Form you accept Mint Dental Hygiene terms and conditions and agree that you have provided correct information to us.

Patients Signature:

Date: