Dental Surgery Pre-Operative Assessment Form

Patient Information

Full Name

Date of Birth

Contact Number

Email

Address

Medical History

Current Medications

Allergies

Past Medical Conditions

Previous Surgeries

Bleeding Disorders

Heart Conditions

Diabetes

Other Important Medical Details

Dental Assessment

Reason for Surgery

Planned Procedure

Pain Level (1-10)

Relevant Dental History

Consent & Notes

Consent Obtained

Clinician's Notes

Date of Assessment

Clinician Name