WELCOME TO OUR PRACTICE

We would be most grateful if you could complete this form. The medical section asks about conditions which may have a bearing on your dental treatment. Please answer these fully even if you don't think it is relevant to dentistry. If you have any queries please do not hesitate to ask our receptionist for help. **Please give as many contact details as possible, especially mobile phone numbers and E-mail addresses.** The practice regularly communicates with its patients by email and sms to confirm appointments. (We do not send any information regarded as personal).

TITLE . . . . . SURNAME. . . . . .FIRST NAME(S). .. . . . . D.O.B . . . . . .

ADDRESS . . . . . .

. . . . . POST CODE . . . . . .E-MAIL..... . . . . .

☎ Home . . . . . Work . . . . . Mobile . . . . . .

OCCUPATION..... NATIONAL INSURANCE NUMBER..... ETHNICITY..... (optional).....

IN CASE OF EMERGENCY PLEASE PROVIDE A CONTACT:NAME.....Number.....

National Health Service Exemptions - If any of the following apply please indicate:
You will need to provide proof of exemption or you may be asked to pay NHS charges.

- ☐ Under the age of 18
- ☐ Aged 18 and in full time education
- ☐ You or your partner are receiving Income Support
- ☐ You or your partner are receiving Income-Related Employment Support Allowance
- ☐ You have a Tax Credit Exemption **CARD**
- ☐ You or your partner are receiving GUARANTEED Pension Credit
- ☐ You or your partner are receiving Income-Based Job Seekers Allowance
- ☐ Possessing HC2 or HC3 Certificate
- ☐ Pregnant or under one year following the birth. (Please give due date or date of birth) . . . . . .

MEDICAL HISTORY - PLEASE ANSWER YES OR NO TO ALL THE FOLLOWING QUESTIONS

Have you or do you suffer from any of the following?

YES/NO Heart problems, angina or stroke
YES/NO Heart Attack
YES/NO High Blood Pressure
YES/NO Do you have a pace maker?
YES/NO Have you ever bled persistently or take blood thinners?
YES/NO Cancer
YES/NO Asthma, bronchitis or other chest condition
YES/NO Diabetes
YES/NO Kidney or Liver problems
YES/NO Hepatitis or HIV/AIDS
YES/NO Drug addiction
YES/NO Recent steroid treatment?
YES/NO Epilepsy or Schizophrenia or any neurological condition
YES/NO Have you received treatment for nerves or depression in the last two years?
YES/NO Blood refused by the transfusion service/you or your family members have sickle cell?
YES/NO Do you carry a medical warning card?
YES/NO Drink 15+ units of alcohol per week?
YES/NO Do you smoke tobacco - if so how many?
YES/NO Do you chew tobacco - if so how often?
YES/NO Do you use an electronic cigarette?
YES/NO Are you pregnant?

PLEASE TURN OVER

(Please note that all information on this form is confidential)

(Revised October 2016)

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YES/NO Other illness, medical condition, or anything else you think we should know about?

If yes – please detail here:

YES/NO Are you allergic to anything, tablets or medicines?

If yes – please detail here:

YES/NO Are you at present, or have you recently taken any medicines, tablets, injections or inhalers?

If yes – please list here:

Name & Address of your regular Doctor. . . . . .
. . . . . .

Do you have any particular worries about your teeth or anything you would like to change?

_____ On a scale of 1-10 with 10 being high, how anxious are you about seeing the Dentist?

PLEASE SIGN AND DATE ONCE ONLY ON THE TOP LINE.

Your Signature . . . . . Date. . . . . .
Your Signature . . . . . Date. . . . . .
Your Signature . . . . . Date. . . . . .
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(Revised October 2016)