Wright Dental Care

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 for help.

Please give as many contact details as possible, especially mobile phone numbers and E-mail addresses.

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

ADDRESS .....POST CODE .....

E-MAIL.....OCCUPATION.....NHS NUMBER.....

TELEPHONE - Home ..... Work ..... Mobile .....

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

GDPR – important (further information on reception noticeboard)

New data protection rules mean we must obtain you permission to contact you. We send information and appointment reminders by text message and email. We also occasionally send out useful information from the practice. **This will only ever be related to dental services**. We will never share or sell your information to a third party under any circumstances unless required to do so by law. Please give your permission to contact you by the following methods (tick all appropriate):

Text (SMS) ☐ Telephone ☐ Email ☐

National Health Service Exemptions – Do you or your partner receive any of the following – please tick:

- ☐ Aged 18 and in full time education
- ☐ Income-Based Job Seekers Allowance
- ☐ Income-Related Employment Support Allowance (ESA)
- ☐ Pregnant or have a baby under one?
- ☐ Universal Credit
- ☐ Income Support
- ☐ GUARANTEED Pension Credit
- ☐ Have an HC2/HC3 Certificate

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 or heart attack? Please state which.....
YES/NO High Blood Pressure
YES/NO Do you have a pacemaker
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 (or chew tobacco) - if so how many a day
YES/NO Do you use an electronic cigarette
YES/NO Do you think you may weigh more than 20 stones/125kg

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

(Revised June 2025)

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 **ALL** here:

Doctors/GP Name and surgery address

Do you have any dental problems that you are aware of? Please provide as much detail as you can.
IT IS ESSENTIAL YOU COMPLETE THIS SECTION FULLY

When did you last attend a dentist NOT including emergency or 111 appointments? ……..

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

Are you interested in any of the following: (please tick)

Invisalign/Clear Aligners ☐

Composite bonding ☐

Teeth whitening ☐

PLEASE SIGN AND DATE

Your Signature . . . . . Date. . . . .

(**Please note that all information on this form is confidential)**
(Revised June 2025)