Confidential Patient Information Form

Title: ...	Surname:	Forename:
D.O.B:	Sex: ...	Occupation:
NHS No:		Where did you hear about us? ...
Address: Postcode:		
Tel (Home):		Mobile:
Tel (Work):		Email:
Next of Kin (Name, Relationship & Tel No):		
GP's Name & Address:		☎ GP:
When did you last visit the dentist & what did you have done?		

ARE YOU CURRENTLY? *(please select)*	yes/no	IF YES, PLEASE GIVE DETAILS
1 Exempt from NHS dental charges (e.g. claiming benefits)…	---	
2 Pregnant. If yes, then please enter you expected due date.	---	
3 Attending hospital/clinic or receiving any treatment from GP	---	
4 Taking any prescribed medication? (tablets, creams, inhalers, injections, contraceptives or HRT)…….……..	---	
5 Allergic to any medicines or materials e.g. latex……	---	
6 On an NHS / Private Dental Care Plan?.....	---	

DO YOU? *(please select)*	yes/no	IF YES, PLEASE GIVE DETAILS
7 Carry a warning card……..	---	
8 Have angina or high / low blood pressure……..	---	
9 Suffer from bronchitis, asthma or any other chest condition	---	
10 Suffer from hay fever, eczema or any other allergy……..	---	
11 Have fainting attacks, giddiness, blackouts or epilepsy……	---	
12 Have diabetes or does anyone in your immediate family….	---	Who? ……
13 Smoke or chew tobacco products. If so, how many per day	---	
14 Drink Alcohol. If so, how many units per week?.....	---	
15 Bruise easily or bleed excessively……	---	
16 Grind your teeth……..	---	
17 Take steroids or have you taken steroids in the last 2 yrs...	---	

HAVE YOU EVER HAD THE FOLLOWING? *(please select)*	yes/no	IF YES, PLEASE GIVE DETAILS
18 Rheumatic fever or cholera……..	---	
19 Heart attack or stroke……	---	
20 Heart surgery or a pacemaker fitted……	---	
21 Liver disease, Kidney disease, hepatitis B, hepatitis C, HIV	---	
22 Joint replacement or other implant……..	---	
23 Bad reaction to general or local anaesthetic……..	---	

WOULD YOU LIKE YOUR DENTIST TO PROVIDE YOU WITH EITHER INFORMATION OR CONSULTATION FOR?	yes/no
24 Tooth Whitening (take home kit or chair-side)……	---
25 Cosmetic dentistry……...	---
26 Dental Implants……	---

27 How do you feel about dental treatment?
28 Is there any aspects concerning your health that you think the dentist should know about?

During the Coronavirus outbreak, additional personal data will be gathered in relation to COVID-19 i.a.w Coronavirus Act 2020.
You will receive SMS texts & emails relating to your appointments as default. To receive relevant offer messages, please tick here: ☐

*Signed: Patient Signature	Self ◯ Parent/Guardian ◯	Date:	Dentist to Countersign

MEDICAL HISTORY UPDATES (Patients, please check that the Health Information on this form is still correct & then sign/date)

Signed: Patient Signature	Self ◯ Parent/Guardian ◯	Date:	Dentist to Countersign
Signed: Patient Signature	Self ◯ Parent/Guardian ◯	Date:	Dentist to Countersign

**Please sign or paste your signature in this box. Else you can write your name in full as a legal representation of your signature.*