THE DENTAL CENTRE

Title ……Forename …… Surname ……

Home Address ……

…… Postcode……

Occupation …… Date of Birth ..... / …… / ……

Email Address ……

Telephone …… Mobile ……

1 Are you currently pregnant?
Yes ☐ No ☐

2 Are you currently receiving treatment from a doctor, hospital or clinic?
Yes ☐ No ☐
If yes please elaborate:

3 Are you currently taking any prescribed medicines (eg tablets, ointments or inhalers, including contraceptive and hormone replacement therapy)?
Yes ☐ No ☐
If yes please provide details of medication:

4 Are you carrying a medical warning card?
Yes ☐ No ☐
If yes, for what?

5 Do you suffer from allergies to any medicines, substances or foods? (eg penicilin, latex/ rubber)
Yes ☐ No ☐
If yes please state:

6 Do you suffer from hayfever or eczema?
Yes ☐ No ☐

7 Do you suffer from bronchitis, asthma or any other chest condition?
Yes ☐ No ☐
If yes please state:

8 Do you suffer from epilepsy, fainting attacks, giddiness or blackouts?
Yes ☐ No ☐
If yes please state:

9 Do you suffer from heart problems, angina, blood pressure problems, or stroke?
Yes ☐ No ☐
If yes please state:

10 Do you or anyone in your family have diabetes?
Yes ☐ No ☐
If yes please specify:

11 Do you suffer from arthritis?
Yes ☐ No ☐

12 Do you suffer from bruising or persistent bleeding following injury, tooth extraction or surgery?
Yes ☐ No ☐

13 Do you have any infectious diseases (including HIV and Hepatitis)?
Yes ☐ No ☐
If yes please state:

14 Have you ever had rheumatic fever?
Yes ☐ No ☐

15 Have you ever had liver or Kidney disease? (eg Jaundice, hepatitis)
Yes ☐ No ☐

16 Have you ever had any other serious illness?
Yes ☐ No ☐
If yes please state:

17 Have you ever had blood refused by the Blood Transfusion Service?
Yes ☐ No ☐

18 Have you ever had a bad reaction to General (GA) or Local (LA) anaesthetic?
Yes ☐ No ☐

THE DENTAL CENTRE

19 Have you ever had a joint replacement or other implant?
Yes ☐ No ☐
If yes please state:

20 Have you ever had treatment that required you to stay in hospital?
Yes ☐ No ☐
If yes please state:

21 Have you ever had heart surgery?
Yes ☐ No ☐

22 Have you ever had brain surgery?
Yes ☐ No ☐

23 Did you ever receive growth hormone treatment before the mid 1980's?
Yes ☐ No ☐

24 Do you have any close relatives (parent, sibling, child, grandparent) with Creutzfeldt-Jakob disease?
Yes ☐ No ☐

25 Approximately how many units of alcohol do you drink per week?

26 Do you smoke any tobacco products?
Yes ☐ No ☐
If yes, how many? _____For how many years have you smoked?_____

27 Have you ever smoked?
Yes ☐ No ☐
If yes, when did you quit? _____How many years did you smoke?_____

28 Do you chew tobacco, pan, use gutkha or supari or have you in the past?
Yes ☐ No ☐

29 Is there any other information which your dentist might need to know about, such as self-prescribed medicines? (eg aspirin)
Yes ☐ No ☐
If yes please state:

30 Do you suffer with thyroid disease?
Yes ☐ No ☐
If yes please circle: Overactive / Underactive

31 Do you have any neurological disorder? Eg, Multiple Sclerosis, Parkinson's disease, Huntington's Chorea
Yes ☐ No ☐

GP Name …… **GP Surgery Phone** ……

GP Surgery Address ……

……

To ensure your safety whilst visiting our practice, we would be most grateful if you could complete the details below:

Next of kin: ……

Next of kin relationship: …… Next of kin contact number: ……

Data protection – *nominated individual*

I , ……....., give permission for Centre for Dentistry to discuss my dental appointments with a nominated individual ……....., on my behalf. This will be limited to making and cancelling of my appointments, unless I otherwise advise. I understand that should this no longer be the case then it is, my sole responsibility to advise The Dental Centre of any changes that may alter this authorisation.

Marketing Preferences: From time to time **The Dental Centre** would like to contact you with Practice news and offers.
Please tick this box if you are happy to receive this communication from us. ☐

Signed

……

Date ..... / ..... / .....

Dentist Signature……