Confidential Details & Medical History Form

We need to take some details from you for our records to ensure that we provide you with the best level of treatment. We will use the contact details you provide us with to contact you.

We store ours records on our dental database which is security and password protected. They are stored in accordance with the Data Protection Act 1998.

We may need to share your information when referring you for dental treatment. Your personal information is not shared or forwarded on to any other organisation or company. If you would like further information about how your dental records are stored please ask our reception team.

Please sign below if you are happy for us to store your personal information.

Signed.....Date.....

Your dental records comprise of computerised/written notes, radiographs (x-rays), digital photographs and stone models of your teeth. We request consent from you for us to use these for demonstration, training and marketing purposes. Your identity will always remain anonymous.

You can withdraw all or part of your consent for this at any time, please let us know in writing.

Please tick the boxes to indicate your consent of the following:
☐ Our use of any digital photographs of you for demonstration, training or marketing
☐ Our use of digital radiographs (x-rays) for training purposes
☐ Our use of any stone models of you for demonstration, training or marketing

Signed……Date……...

Full Name ☐ Male ☐ Female How do you prefer to be addressed?	Date of Birth
Address (Inc Postcode)	Home Tel Work Tel Mobile Tel
	Email Address
Name of Next of Kin Contact Number Relationship to You	Occupation (Previous if retired)
Name, Address and Phone Number of GP	
Are you happy for us to leave messages concerning change of, or confirmation of your appointments on: ☐ Your home answer phone ☐ Your mobile answer phone ☐ With a family member/ friend ☐ With a work colleague ☐ Other	
Please state the names and relationship of anyone authorised by you to contact us on your behalf concerning any of the following: Appointments, change of details e.g. address, aspects of treatment, payments for treatment, other please state……. Name Relationship to you	

Medical History

Are you taking any prescribed medication? (E.g. tablets, ointments, injections, or inhalers, including contraceptives and hormones replacement therapy) ☐Yes ☐No
Please give list or show your repeat prescription to your dentist.

In particular, do you take Aspirin, Warfarin, or other blood thinning medicines, Steroids, Contraceptive Pill, Methotrexate (Bisphosphonates) or medication for Osteoporosis, Angina, or Asthma? Please give details……. ☐Yes ☐No

Are you taking any self-prescribed medicines such as Aspirin or herbal remedies such as Ginkgo Biloba, Vitamin E or St John's Wort? If Yes, please give details……. ☐Yes ☐No

Do you smoke or use tobacco products? ☐Yes ☐No
If yes, how many a day?..... For how many years have you smoked?.....
Have you smoked or used tobacco products in the past? ☐Yes ☐No
When did you stop smoking?..... How many did you smoke a day?.....
Do you have a tobacco chewing habit? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No
If yes, how many units per week? (A unit of alcohol is half a pint of lager, a single measure of spirits. A small glass of wine/aperitif is 1.5 units)…….

Do you have any allergies to any medication, food/drinks, pollen (hay fever) or other materials? ☐Yes ☐No
What reaction did you have?.....

Have you ever had in the past:
An adverse reaction to dental material? ☐Yes ☐No
Ill-effects following dental treatment? ☐Yes ☐No
A bad reaction to general or local anaesthetics? ☐Yes ☐No
Please give details…….

Do you have any heart problems? ☐Yes ☐No

Details: e.g. Heart Disease, Heart Attack, Angina, Valve Disease, Irregular Heart Rhythm, or Swelling of Ankles, Infective Endocarditis, Pacemaker, Heart Surgery, Valve Replacement, Heart Murmur
Please give details…….

Do you have any lung problems? ☐Yes ☐No

Details: e.g. Asthma, Bronchitis or any other breathing problems
Please give details…….

Have you ever had any of the following?

	Yes	No
High or Low Blood Pressure	☐	☐
History of Bruising Easily	☐	☐
Excessive Bleeding	☐	☐
Jaundice? (Not Including at Birth)	☐	☐
Hepatitis/Liver Problems	☐	☐
Kidney Problems	☐	☐
Stomach Ulcer or Heartburn	☐	☐
Digestive Problems	☐	☐
Rheumatic Fever	☐	☐
Diabetes	☐	☐
Dizziness, Blackouts or Fainting	☐	☐
Epilepsy or any kind of Fit	☐	☐
Severe Arthritis	☐	☐
Stroke or Mini Stroke	☐	☐
Psychiatric Illness e.g. Depression, Anxiety, Schizophrenia	☐	☐
Anxiety about dental treatment	☐	☐
Osteoporosis	☐	☐
Bone or Joint Disease	☐	☐
History of Organ Transplant, Implant or Artificial Joint e.g Hip Replacement	☐	☐
Radiotherapy/Chemotherapy	☐	☐
Any recent blood tests	☐	☐
Anaemia	☐	☐
Hepatitis A, B or C	☐	☐
HIV/AIDS or any other Blood Borne Disease	☐	☐
History of possible Exposure to Blood Borne Virus	☐	☐
Blood Refused by the Blood Transfusion Service	☐	☐
Drug Dependency	☐	☐
Severe Headaches	☐	☐
Treatment with steroids in the past 2 years	☐	☐
Have you been issued with any warning cards by a medical practitioner (e.g. steroids, warfarin)	☐	☐
Are you?		
Attending or receiving treatment from any doctor?	☐	☐
Females: Any likelihood of pregnancy?	☐	☐
If so are you breast feeding?	☐	☐

If you have answered **Yes** to any of the list of the left please give further details below:

In the past 5 years have you been hospitalisation for:

Operations? ☐Yes ☐No

Serious illness? ☐Yes ☐No

Treatment that requires you to go to hospital? ☐Yes ☐No

Please give details…….

Is there anything else about you that the dentist should know?

Please give details…….

I confirm that all of the information I have provided on this form is accurate and true. I understand that falsifying or withholding information may prevent me from receiving accurate treatment for my needs.

Signature.....Date.....