Confidential Medical History

Title: _____Forename(s):_____Surname:_____
Date of birth: ____/___/___
Address:_____
_____Post code:_____
Contact number: Home_____Work_____Mobile_____
Email address: _____
Occupation: _____ How long since your last dental treatment? _____
Rate on a scale of 1 to 10 how nervous you are? 10 as being phobic of dentists: _____
GP name address _____
Please tick the boxes appropriate to you and list any details in the boxes provided:

Question	Yes	No	Details
Currently receiving treatment from a doctor, hospital or clinic?			
Currently taking any prescribed medicines?			
Currently pregnant?			
Allergic to any medicines or substances in particular Latex?			
Taking any blood anti- coagulants, such as warfarin, aspirin or heparin?			
Diabetic?			
Suffer from bronchitis, asthma or other chest conditions?			
Suffer from fainting attacks, giddiness, blackouts or epilepsy?			
Suffer from heart problems, angina, blood pressure problems or stroke?			
Suffer from arthritis?			
Carry a medical warning card?			
Suffer from bruising or persistent bleeding following injury, tooth extraction or surgery?			
Suffer from any infectious diseases (including HIV and hepatitis)			
Ever had rheumatic fever or cholera?			
Ever had liver disease (e.g., Jaundice, hepatitis) or kidney disease			
Had any other serious illness?			
For patients who suffer with dementia or Alzheimer's - please indicate how co-operative the patient will be with opening their mouth and how they will behave during a dental examination?			
Ever had blood refused by the Blood Transfusion Service?			
Ever had a bad reaction to general or local anaesthetic?			
Ever had a joint replacement or other implant?			
Ever had heart surgery?			
Do you regularly drink more than 21 units of alcohol per week?			

Do you smoke any tobacco products now (or in the past)			
Is there any other information the dentist might need to know about?			

Please Turn Over ---------->

If there is anything that you would like to discuss with the dentist, but prefer not to write down, please tick this box: ❑

If you would rather that we do not text you with appointment reminders, please tell the receptionist and tick this box: ❑

I confirm the above information is correct to the best of my knowledge. I understand that any costs and treatment I need will be explained to me by the dentist. I am aware that no credit is given, and I will pay for treatment on the day of appointment. (Crowns, bridges, implants, orthodontic appliances and dentures will have to be paid for before the fitting date usually on the impression taking appointment). I also understand that should I not give 1 working days' notice for cancelling or moving any appointment that I may be charged a minimum of £50.00.

By signing below, you agree that you have read the fair processing notice reference below and are giving consent for us here at Clinic for Implant & Orthodontic Dentistry to process and hold your data. We will not give your information to any third party without your prior consent. All information will be held in the strictest of confidence in line with the GDPR (General Data Protection Regulation). To read our fair processing notice either go on the website http://dental-worthing.co.uk/gdpr-fair-processing-notice-for-patients, have a look in the patient information folder or ask for a copy of it.

Signed: Date: