Dental Practice on the Hill

Healthy teeth. Happy smile.

All information on this form is strictly confidential and will only be used to serve you better.

Title	Mr / Mrs / Dr / Miss / Ms / Mst / Mx	Date of birth	.....
First name	.....	Sex	Male / Female / Other
Surname	.....	Home phone	.....
Address	.....	Mobile phone	.....
	.....	Work phone	.....
	.....	E-mail address	.....

Occupation .....

When did you last visit a dentist? .....

How did you hear about us? .....

GP (Doctor) Name	.....	If female:	Are you pregnant	Yes or No
Practice Name	.....		When are due?	.....
Address	.....		Do you have a child less than one year old?	Yes or No
	.....			

Do you have a current exemption certificate which entitles you to NHS treatment? Yes or No

If yes, which exemption certificate do you have? .....
(please bring proof to your appointment)

If no, you will be accepted as an independent patient: please see our fee guide

Here at the practice we take your privacy seriously. We would like to contact you with important notifications, such as appointment reminders. In order to do this we might need to pass your details to third-party communication companies who will deliver these messages to you and use your details solely for the purpose of delivering this content. You can opt out at any time.

I consent for my details to be used for the purposes outlined above. ☐

PLEASE TURN OVER

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ARE YOU:	YES	NO	DETAILS
Attending or receiving treatment from a doctor, hospital clinic or specialist?			
Are you an expectant or nursing mother?			
Taking any medicines from your doctor? (Please provide us with a repeat prescription to be scanned onto your records)			
Taking or have taken steroids in the last 2 years?			
Allergic to penicillin, other medicines, foods, materials?			
HAVE YOU:			
Ever been told you have a heart murmur or heart problem, angina, blood pressure, heart attack?			
Had rheumatic fever or chorea (st vitus dance)?			
Had jaundice, liver, kidney disease or hepatitis?			
Had a joint replacement?			
Had a bad reaction to a general or local anaesthetic?			
Have you ever been hospitalised? If so, what for and when?			

DO YOU:	YES	NO	DETAILS
Suffer from hayfever, eczema, or asthma?			
Have a pacemaker, or have you had any form of heart surgery?			
Bruise easily, or following a tooth extraction, surgery or injury have you or your family bled so as to cause a worry?			
Have fainting attacks, giddiness, blackouts or epilepsy?			
Have diabetes or does anyone in your family?			
Have arthritis?			
Are you a smoker/ ex-smoker? If yes, how many cigarettes do you/did you smoke per day?			
How many units of alcohol do you consume per week?			
Do you carry a warning card?			
Have any blood borne viruses including HIV?			
Do you have a high sugar or fizzy drink intake?			
Are there any other aspects of your health that we should know about?			

Form completed by: Self / Parent / Guardian Signature _____ Date _____

Countersigned by Dentist _____ Date _____