West Street Dental practice

PATIENT INFORMATION (PLEASE PRINT)				
Patient's last name:	First:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Sex: ❑ M ❑ F
Address:			Postcode:	Date of birth:
Tel no. (home)	Mobile:		Occupation:	
Are you exempt from paying for NHS Dental treatment ❑ **Y** ❑ **N** **If yes please state exemption**				
Name and address of your doctor				

NHS Number:

MEDICAL HISTORY		
(Certain medical conditions can affect dental treatment and vice versa) **ALL DETAILS WILL BE STRICTLY CONFIDENTIAL**		
Do you have or have you ever suffered from:		**Notes and list of medications below:**
Rheumatic fever?	❑ Yes ❑ No	
Any heart complaint, heart surgery or stroke?	❑ Yes ❑ No	
Diabetes?	❑ Yes ❑ No	
Epilepsy or fainting attacks?	❑ Yes ❑ No	
Chronic bronchitis or asthma?	❑ Yes ❑ No	
Hepatitis?	❑ Yes ❑ No	
Excessive bleeding?	❑ Yes ❑ No	
High blood pressure?	❑ Yes ❑ No	
Any other serious illnesses?	❑ Yes ❑ No	
Do you carry a medical warning card?	❑ Yes ❑ No	
Are you pregnant?	❑ Yes ❑ No	
Please tick or tell the dentist if you are HIV positive	❑ Yes ❑ No	
In the past 2 years have you undergone any operations?	❑ Yes ❑ No	
In the past two years have you been treated with hydro-cortisone or corticosteroids?	❑ Yes ❑ No	
What is your average weekly consumption of alcohol?		
Do you smoke? ❑ Yes ❑ No		If yes, what is your average per week?
Do you have or have you ever suffered from any other serious illnesses?	❑ Yes ❑ No (if yes, please give details below)	
Are you allergic to any medicine, tablets, substances or latex?	❑ Yes ❑ No (If yes, please list)	
Have you ever had a joint replacement? ❑ Yes ❑ No		

If you are not sure of any of the questions, or if your medical circumstances change, please inform the Dental Surgeon

Patients signature.....**Date**.....