Confidential Medical History

St.James Dental
DENTAL AND COSMETIC CARE

Name & Title:
Address:
Home Phone:
Gender:

DOB:
Email:
Mobile:
NHS No:

Name of Doctor: Practice Name: Practice Phone:	Emergency Contact: Emergency Contact Phone: Relationship:

Habits		Smoke tobacco products? (Per day)		High sugar/ frequency	Details:
		Chew tobacco, pan, gutka, supari (Per day)		Lots fizzy/acidic drinks	
		Consume alcohol? (units per week)		Recreational drugs	
Heart		Rheumatic Fever		Heart Murmur	Details:
		High Blood Pressure		Angina	
		Heart Surgery		Thrombosis	
		Pacemaker Fitted		Other Heart condition	
Blood		Hepatitis B		Anaemia	Details:
		H.I.V.		Sickle Cell	
		Abnormal Blood Test Result		Haemophilia	
		Blood refused by transfusion service		Other Blood condition	
Allergies		Penicillin		Latex	Details:
		Hay Fever		Medicines	
		Anti-Tetanus Serum		Plants	
		Eczema		Foods	
		Reaction to General Anaesthetic		Aspirin	
		Reaction to Local Anaesthetic		Other Allergy	
Warnings		Pregnant or possibly pregnant		Problem being reclined	Details:
		Antibiotic Cover required		Steroids in last 2 years	
		Anything else your dentist should know		Warning Card	
		Bruising or persistent bleeding after injury, surgery or tooth extraction			
		Currently under treatment of a doctor, hospital or clinic			
		Any other treatment that required you to be hospitalised			
Chest		Bronchitis		Emphysema	Details:
		Cystic Fibrosis		Pneumonia	
		Pleurisy		Chest Surgery	
		Asthma		Other Chest Condition	

Medication	List and state doses for any prescribed medicines, tablets, ointments, injections or inhalers (inc. contraceptives and HRT) you are taking:

Other		Liver Disease (e.g. jaundice)		Kidney Disease	Details:
		Diabetes / Family with Diabetes		Epilepsy	
		Acid Reflux or Eating disorder		Hiatus Hernia	
		Bone or Joint disease		Artificial Joint	
		Fainting Attacks or Blackouts		Giddiness	
		Any past Serious or Infectious disease		Cancer	

Signed by: ..... Date:

Please see reverse

Data Protection

Name: DOB:

How would you like to be reminded of your appointments?							
Landline call		Mobile call		Email		Text Message	

I give permission for details of my appointments and health information to be left by the following means:					
Home telephone/voice message		Mobile phone/voice or text message		Email	
Work telephone/voice message		Would you like to go paperless?			

I give permission for the following individuals to access this information if required: (We will NOT be able to discuss your appointment times or your protected health information with anyone not listed below)
Name: Relationship:

We carry out audits to maintain and improve our standard of care. Could you please consent to your records being included in an audit, your confidentiality is assured.	Yes	No

Are you happy to receive information on our products, services and promotions?	Yes	No

Where did you hear about us?							
Yellow Pages		Website		Quedgeley News		Hardwicke Matters	
Family/Patient Referral	(Name)			Other			

When did you last visit a dentist?	
Is there anything you would like to change about your smile?	

Would you like to talk to us more about any of the following procedures?							
Implants		Orthodontics		Sedation		Facial Aesthetics	
Tooth Whitening		Snoring Device		Tooth Wear			

Patient Confirmation

I am happy to undergo dental procedures once they have been explained to me and discussed with me by my dental care professional. I assume the responsibility for payment of all fees associated with my dental procedures on the date it is received unless arranged otherwise.

Print Name	Signature	Date

At St James Dental we take great care with all the Personal Data we hold to ensure we comply with best professional practice and with the law. For a full copy of our Data Privacy Notice please ask at reception or see our website.

Completed by	Patient		Parent		Guardian		Carer	