BAY HOUSE
DENTAL PRACTICE

# PLEASE COMPLETE IN BLOCK CAPITALS

At Bay House Dental Practice, 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.

***Like all dentists, we ask patients for information about their general health to help us to treat them safely. All information will be kept strictly confidential.***

**NHS No.**_____ Title_____ Surname_____

Forenames _____ Date of birth _____

Address _____

_____ Postcode _____

Preferred Contact Number/Numbers_____

*Email address*_____

Emergency contact number (next of kin)_____

Occupation _____Date of last dental treatment _____

GP's name _____ _____GP's telephone_____

GP's address _____

| **ARE YOU CURRENTLY?** | **YES** | **NO** | **GIVE DETAILS** |
|---|---|---|---|
| Pregnant | | | |
| Receiving treatment from a doctor, hospital or clinic? | | | |
| Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)? Name/Names of Medication PLEASE WRITE IN BLOCK CAPITALS. | | | |
| Taking over-the-counter medication? | | | |
| Carrying a medical warning card? | | | |

| | | | | |
|---|---|---|---|---|
| Do you consume alcohol? | If YES, how many units per week? | | NO | IN THE PAST |
| Do you smoke any tobacco products? | If YES, how many per day? | | NO | |
| Do you take any recreational drugs? | YES, give details | | NO | |
| Do you chew tobacco, pan, use gutkha or supari | YES | | NO | |
| Would you like help to stop smoking? | YES | NO | If so please ask your dentist or Hygienist for information. | |
| **Have you had any Covid-19 immunisation Jab** | Yes | No | | |



PTO

| | | |
|---|---|---|
| **If a referral is needed for secondary care (e.g. Dental Hospital) are you happy for the provider to access your medical notes from your GP?** | YES | NO |
| **Do you weigh more than 140kg (22 stone/308lbs)** an answer is required | YES | NO |
| **Health and Safety, whilst we appreciate that this is a delicate issue, we are required to inform our patients that there is a weight limit on our dental chairs of 140kg, , If you believe you weigh above this amount please let your dentist know as we will not be able to lie you flat in the chair to proceed with any treatment** | | |

| ***DO YOU SUFFER FROM*** | **YES** | **NO** | **GIVE DETAILS** |
|---|---|---|---|
| Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods? | | | |
| Hay fever or eczema? | | | |
| Breathing difficulty, Bronchitis, asthma or other chest condition? | | | |
| Feeding, swallowing problems (PEG, food supplements)? | | | |
| Fainting attacks, giddiness, blackouts, epilepsy? | | | |
| Cardiovascular disease (e.g. angina, atrial fibrillation)? | | | |
| Blood pressure or circulation problems? | | | |
| Stroke? | | | |
| Metabolic problems (e.g. Thyroid problems, steroid treatment)? | | | |
| Diabetes TYPE 1 OR TYPE 2 (or does anyone in your family)? | | | |
| Arthritis osteoporosis or other bone disorder? | | | |
| Do you have memory problems or dementia? | | | |
| Mental Health Problems (e.g. depression, anxiety, bipolar, schizophrenia, panic attacks)? | | | |
| Bleeding Disorders, (e.g. taking blood thinner meds Warfarin, persistent bleeding following injury, tooth extraction or surgery, bruising? | | | |
| Sleep apnoea, loud snoring sleep disturbance? | | | |
| Any infectious diseases including HIV, Hepatitis, TB, MRSA Herpes (cold sores) | | | |
| ***DID YOU, AS A CHILD OR SINCE, HAVE:*** | **YES** | **NO** | **GIVE DETAILS** |
| Rheumatic fever or chorea? | | | |
| Liver disease (e.g. jaundice, hepatitis) or Kidney disease? | | | |
| Any other serious illness? | | | |
| A bad reaction to general or local anaesthetic? | | | |
| A joint replacement or other implant? | | | |
| Undergone hospitalisation that may affect Your dental care? | | | |
| Heart surgery, Heart Murmur, Heart Valve Replacement, a pacemaker or shunt? | | | |
| Brain surgery? | | | |
| Any further information:- | | | |

FORM COMPLETED BY (Please tick) Self ☐ Parent ☐ Guardian ☐ Relationship _____

SIGNATURE _____ Date _____