ABBEY DENTAL SURGERY

Surname: Mr / Mrs/ Miss…….....Sex: Male/Female
Forename(s)……Ethnicity…….
Address……..
Post Code…….Occupation……
Tel No: Home…….Mobile……
Date of Birth…….NHS Number……...
Email……..
G.P. Name & Address……

	YES	NO	IF yes, please give details
Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?			
Are you taking any medicines, tablets, drugs or injections or using any creams, ointments or inhalers?			
Are you taking or have you taken steroids in the last 2 years?			
Are you allergic to penicillin?			
Are you allergic to any medicines, foods or materials?			
Do you carry a warning card?			
Are you/maybe pregnant or a nursing mother?			
Have you any infectious diseases (Including HIV and hepatitis)			
Have you had rheumatic fever or chorea?			
Have you had jaundice, liver or kidney disease or hepatitis?			
Have you ever had a stroke?			
Did you as a child or since have any other serious illness?			
Have you ever been told you have a heart murmur, heart problem, angina or high blood pressure?			
Have you ever had your blood refused by the Blood Transfusion Service?			
Have you ever had a bad reaction to a local or general anaesthetic?			

Have you had a joint replacement or other implant?			
Have you been hospitalised for any reason?			
Do you have arthritis?			
Do you have a pacemaker or have you had heart surgery?			
Do you suffer from hayfever, eczema or any other allergy?			
Do you suffer from asthma, bronchitis or other chest conditions?			
Do you have fainting attacks, giddiness, blackouts or epilepsy?			
Do you have diabetes or does anyone in your family?			
Do you bruise easily or suffer persistent bleeding following a tooth extraction or injury?			
Do you suffer from cold sores? If yes when was your last one?			
Do you think there are any other aspects, concerning your health, that your dentist should know about?			

On average, how much of the following do you consume per day? (E.g., 1 Pint = 3 units)	Cigarettes: Alcohol:			
Do you chew tobacco products now (or did you in the past)			**In Past**	times per day

Have you had any Covid-19 vaccinations? YES ☐ NO ☐
If yes please tick which ones below: -

First Dose ☐ Second Dose ☐ Booster ☐ Second Booster ☐ Third Booster ☐

GDPR Communication Consent

The practice can contact me about my treatment by either of the options below. I have given the correct contact details and I understand that I am responsible to inform the practice of any changes and I can withdraw consent at anytime. The practice can contact me via:

Email ☐ Text ☐ Both ☐

Next of Kin Details in case of Emergency

Name……Relationship to You……
Contact Number……