EASTCOTE LANE
DENTAL PRACTICE

CONFIDENTIAL PATIENT FORM

Dr/Mr/Mrs/Miss/ Ms

SURNAME:_____**FIRST NAME:**_____

Date of Birth ___/___/_____

Home Address: _____

Post Code: _____

Home Phone: _____ Mobile_____

Email address: _____

How would you prefer to be contacted? **(Please circle):** Home phone / mobile / email / post

Occupation: _____

Name and Contact details of Health Visitor or Social Worker:_____

ORAL HEALTH HISTORY

Name of dentist last seen: _____

Approximate date of last dental visit and treatment received: _____

Do you have any dental pain or concerns at present? Yes / No

Please provide details: _____

Have you ever experienced any problems in the past during or after receiving dental treatment? Yes / No

Please provide details: _____

- How often do you brush your teeth? _____
- Do you use a mouth wash or /and dental floss? Details:_____
- Do you smoke: Yes / No If yes how many a day / week _____
- Do you drink alcohol Yes / No If yes how much a week _____

Please provide a list of snacks and drinks you eat/ drink and how often

e.g tea twice a day with 2 sugar, a bar of chocolate twice a week, crisps daily etc

_____

_____

Name and contact details of Health Visitor and/or Social Worker:

_____

_____

Thank you for completing this form.

EASTCOTE LANE DENTAL PRACTICE, 3 EASTCOTE LANE, SOUTH HARROW, HA2 8BW

TEL: 0208 422 1857

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MEDICAL HISTORY

Name and address Medical Doctor (GP) Surgery:

_____

_____

1. Do you currently have any medical conditions or are ongoing medical treatment? Yes / No

Please provide details: _____

2. Have you been a patient in hospital during the past two years? Yes / No

Please provide details: _____

3. Do you suffer from or have any known alleriges? Yes / No

Please provide details: _____

1. Do you suffer from or have you ever had any of the following? If so, please tick as appropriate.

- ☐ Rheumatic Fever
- ☐ Heart Trouble
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Arthritis
- ☐ Hepatitis - Specify type A, B, C
- ☐ Bronchitis or Chest Problems
- ☐ Severe Headaches
- ☐ Epilepsy
- ☐ Anaemia
- ☐ Diabetes
- ☐ Kidney Trouble
- ☐ Gastric Problems
- ☐ Cold Sores
- ☐ Depressive Illness
- ☐ Drug Dependence

2. Have you ever had any prosthetic surgery? (Eg Heart Valve or Hip Replacement) Yes / No

Details: _____

7. Are you pregnant? Yes / No If so, how many weeks: _____

8. Are you HIV positive? Yes / No

Please **clearly** list any Medication you are taking:

_____

_____

_____

_____

Dentist Signature:.....

Patient Signature:..... **Date:**.....

Thank you for completing this form.

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CONFIDENTIAL PATIENT FORM

EASTCOTE LANE DENTAL PRACTICE COMMUNICATION CONSENT FORM

We process personal data for the purposes of providing optimum healthcare, sending important updates to you, providing you with news about treatments and what is happening at the practice and informing you about our services and promotions. You can withdraw your consents at any time to or by calling 0208 4221857

I would like the dental practice to contact me via:

- Email
- Telephone /Text

I would like to receive important practice announcements and updates including changes to opening and closing dates and times.	Yes	No
I would like to receive details of practice services and promotions	Yes	No
I am happy to be contacted to provide feedback on my recent visit	Yes	No
Other:	Yes	No

Your personal information will never be passed to third parties unless we are making a professional referral for you. If we have your consent for referral to another health care provider we will send them just the information that they need to provide the necessary assessment, tests or treatments. For further details about how we process your personal information please see contact us at Eastcote Lane Dental Practice, 3

Disclaimer for claiming for exemption from NHS Dental Charges

I (PRINT NAME) _____understand that I have claimed for exemption from NHS Dental Charges and Eastcote Lane Dental practice will not be responsible or liable for any penalty notices which I receive from NHS Business Services Authority in connection with incorrect or false claims made in relation to my exemption.

Patient Signature:_____

Date:_____

Thank you for completing this form.

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