Dr /Mr /Mrs /Ms /Miss **Name:** **Surname:** **Date of Birth:**

Home Address: _____

Home Phone: _____ Mobile Phone: _____

E-mail: _____ Occupation: _____

Details of person to contact in an emergency: Name: _____Phone Number: _____

Medical Doctors Name: _____ Phone (If known): _____

1. Are you receiving any medical treatment at the present time? Yes / No If yes details: _____
2. Have you been a patient in hospital during the past two years? Yes / No If yes reason: _____
3. Have you taken any medicines (tablets, capsules or injections) during the past two years? (eg Warfarin, Bisphosphonates, Aspirin) Yes / No If yes details: _____
4. Have you experienced any allergies or unusual effects from any tablets, drugs, injections or anaesthetic?.....Yes / No If yes details: _____
5. Are you, or have you been, under the care of a doctor during the past year?.....Yes / No If yes reason: _____
6. Have you ever had any of the following? If so, please tick as appropriate.

☐ Rheumatic Fever	☐ Epilepsy	☐ Respiratory Disease	☐ Auto-immune disorder
☐ Heart Problems	☐ Arthritis	☐ Asthma	☐ Radiation Therapy
☐ High Blood Pressure	☐ Diabetes	☐ Depressive Illness	☐ Hepatitis - Specify type A, B, C
☐ Anaemia	☐ Kidney Trouble	☐ Drug Dependence	☐ HIV Positive
☐ Excessive Bleeding	☐ Gastric Problems	☐ Cold Sores	☐ At risk to HIV exposure
☐ Pacemaker	☐ Cancer	☐ Carrying a Warning Card	

7. Have you had any prosthetic surgery? (eg Heart Valve or Hip Replacement)…… .Yes / No If yes details: _____, when _____
8. If female, Are you or do you think you may be pregnant? Yes / No If yes, expected Due Date: _____
9. Do you smoke? Yes / No If yes, how many per day? _____For how long _____
10. How many units of alcohol do you drink per week? (*A unit is half a pint of lager)* _____

Covid-19 Screening:

1- Do you have fever or have you felt hot or feverish recently (14-21 days)? .....Yes / No
2- Are you having shortness of breath or other difficulties breathing?..... Yes / No
3- Do you have a new continuous cough or experienced recent loss of taste or smell ?..... Yes / No
4- Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?..... Yes / No
5- Are you in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment……Yes / No
6- Have you travelled in the past 14 days to any regions affected by COVID-19? (as relevant to your location) ……Yes / No
7- Covid-19 Vaccination: ☐No Vaccination ☐First Vaccination. ☐Second Vaccination. ☐ Vaccination Booked for……..

DENTAL HISTORY

1. Approximate date of last dental visit:_____
2. Do you have Dental pain or a Dental problem at present? Yes / No If yes details: _____
3. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches?.....Yes / No
4. Do you become anxious or uncomfortable when you are having dental treatment?.....Yes / No
5. Would you like more information about our cosmetic treatments to improve the aesthetics of your smile?.....Yes / No

Referred to us by:

☐ Google Search ☐ Another patient or friend (Name)_____
☐ Street Sign ☐ Other (Please specify) _____

Signed: Patient _____ **Date:** _____ **Signed:** Dentist_____