Completed by: Self Parent Guardian

Patient's Signature: Date: / /

Dentist's Signature: Date: / /

Preferred Contact

At Pont Steffan we offer a service to remind our patients of upcoming appointments and a reminder to make an appointment. Occasionally we may like to contact you to amend an appointment. We can offer this in the form of text messages, emails, phone calls and letters.

Please tick your preferred method of contact: **Home Tel.** **Mobile** **Email** **Work Tel.** **Post**

Data Privacy

At Pont Steffan Dental, we take great care with all the personal data. For a full copy of our Privacy Notice please ask at reception, email reception@psdental.co.uk or download from our website. Do you consent for us to:

	Yes	No
Send text and/or email reminders for appointments booked or due?		
Send you practice updates? i.e. Opening hours/ practice news.		
Send practice marketing? i.e. Offers and new services		
Leave messages for you? i.e. Answer phone/ family member/partner		

If 'yes' please give name(s):

Are you happy for a family member to make or change appointments for you?

If 'yes' please give name(s):

Patient's Signature: Date: / /

Confidential Medical History Form

We ask you for information about your general health to help us treat you safely. Please write your contact details below, answer the health questions inside then sign the form on the back page. We will use this form at later visits to discuss any change in your general health. All information will be kept strictly confidential by the people caring for you.

Surname:

First Name/s:

Title: **Sex: Male** **Female**

Date of Birth: / /

Address:

Postcode:

Home Telephone:

Mobile:

E-mail:

Occupation:

Doctors Name & Address:

Doctor's Telephone:

Emergency Contact: **Name:**

Number:

Are you currently:

	Yes	No	Give Details
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)?			
Carrying a medical warning card?			
Pregnant or possibly pregnant?			
Heavier than 180kg (28 stone)?			

Have you ever suffered from:

	Yes	No	Give Details
Allergies to medicines (eg. Penicillin), substances (eg. Latex) or foods?			
Bronchitis, asthma or other chest conditions?			
Fainting attacks, giddiness, blackouts or epilepsy?			
Heart problems, angina, blood pressure problems or stroke?			
Heart surgery?			
Bone or joint disease?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any other serious illness or infectious disease? (eg. HIV)			
Any neurological conditions? eg. Alzheimers, Parkinsons, CJD			
Liver disease (eg. Jaundice, hepatitis) or kidney disease?			
Blood refused by the Blood Transfusion Service?			
A bad reaction to general or local anaesthetic?			
Treatment that required you to be in hospital?			
Diabetes (or does anyone in your family)?			

Alcohol:

How many units of alcohol do you drink per week?

units per week.

Tobacco use:

	Yes	No	In the Past
Do you smoke any tobacco products now or in the past?			
			times per day
Do you chew tobacco, pan, use gutkha or supari now or in the past?			
			times per day

Please give any other details which your dentist might need to know, such as self-prescribed medicines (e.g. Aspirin) or any disabilities.