This page is double sided

OAK HILL DENTAL & IMPLANT CENTRE

Medical History Questionnaire

This provides the dentist with important information required for your Dental treatment and Oral Health Care.

YOUR DETAILS (PLEASE USE CAPITAL LETTERS)

Please fill in all details do not leave any boxes blank

Title_____

Surname: _____ **Forename:** _____

FULL Home Address:_____ **Date of Birth:** _____

_____ **Home Phone:** _____

_____ **Mobile Phone:**_____

_____ **Email:** _____

Occupation:_____ **NHS No:** _____

(This is a 10 digit number no letters if unknown please contact your GP)

EMERGENCY CONTACT DETAILS: (Details of someone we can contact on your behalf if needed)

Name: _____ **Phone Number**:_____

Relationship: _____ **Are they a patient at the practice? Yes No**

SOCIAL HISTORY

Do you drink alcohol? Yes No If yes, how many units a week _____

Do you smoke? Yes No If yes, how many a day _____

On a scale of 1-10 (10 being very anxious), how **anxious** are you when receiving dental treatment?

1 2 3 4 5 6 7 8 9 10

DETAILS OF GMP (Doctor) :

GMP Practice Name _____

GP Address:_____

Telephone _____

Most medical conditions can affect dental health and any treatment we may provide you. It is important that our records are kept up to date with any changes to your health and general well-being.
Please complete the medical history questionnaire overleaf and answer ALL questions asked. All details you provide will be strictly confidential.

Please turn over for medical history questionnaire

MEDICAL HISTORY

Do you, or have you ever suffered from any of the following:

Please tick yes or no in each box*DO NOT LEAVE ANY BOXES BLANK*				
Heart Conditions:		***Yes***	***No***	***Details please***
	Rheumatic fever			
	Heart Surgery			
	High/low Blood Pressure			
	Pacemaker			
	Angina			
	Heart Murmur			
	Any other heart conditions			
Blood Conditions:		***Yes***	***No***	***Details please***
	Hepatitis A,B,C, D			
	HIV/AIDS			
	Anaemia			
	Sickle Cell			
	Haemophilia			
	Any other blood conditions			
Chest Conditions:		***Yes***	***No***	***Details please***
	Bronchitis			
	Cystic fibrosis			
	Asthma			
	COPD			
	Any other breathing/chest conditions			
Other Conditions:		***Yes***	***No***	***Details please***
	Diabetes			
	Epilepsy/fainting attacks			
	Cancer/radiotherapy			
	Osteoporosis			
	Cold sores			
	Anxiety or Depression			
	Liver Disease			
	Kidney Disease			
Allergies		***Yes***	***No***	***Details please***
	Penicillin			
	Hayfever			
	Latex			
	Medicines			
	Other			

Are you pregnant? Yes No Not applicable

Do you take any **regular medications**? Yes No (If yes, please give details below)

_____

_____

_____

(If you are on multiple medications, please provide us with a list/repeat prescription which can be scanned)

Declaration: I can confirm all details are correct as per my knowledge

Signed: _____ **Date:**

(If patient is 16 or younger, parent or guardian must sign)

DENTAL HISTORY AND CONSENT FOR TREATMENT

Patient Name: _____

Reason for seeking dental care at this time: _____

How did you hear about Oak Hill _____

Date of last dental visit: _____ Date of last xrays: _____

Reason for last dental visit: (Please circle) Routine Emergency

Former Dentist: (Please circle) NHS Private Where: _____

How often do you: Brush _____ times per day. Regularly Occasionally

Floss _____ times per day. Regularly Occasionally

How do you feel about dental treatment: (Please circle)

Relaxed A little uneasy Tense Anxious Very Anxious

Do you have or have you ever had any of the following? Please circle.

Aching or sensitive teeth	Broken filling	Areas of food traps	Unfavourable dental experience
Sensitive or bleeding gums	Loose teeth	Difficulty opening wide	Growths or lesions in your mouth
Broken or missing teeth	Bad breath	Clicking or popping in jaw	Cold sores
Grinding or clenching	Swollen glands	Jaw pain or tiredness	Dry mouth
Swelling or lumps in mouth	Gum infection	Orthodontic treatment	Other _____

If you could change your smile, what would you change?

Remove unsightly fillings	Straighten teeth	Change shape of teeth	Close gaps between teeth
Replace missing teeth	Whitening	Make teeth same colour	Other _____

Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs.

I authorise the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to consulting professionals at the practice for discussion of my case. I understand this can help with giving me the best course of treatment.

I understand that I am personally responsible for payment of all fees for dental services provided in this practice for me. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Signature _____ Date _____ **PTO**

Privacy statement

Here at Oak Hill Dental Practice we take your privacy seriously.

From time to time we would like to contact you with details of other dental services that we provide or introduce, such as additional clinics or introductory treatment offers.

To do this, we need to ask you for your consent before sending you this type of promotional message.

We hope that you will appreciate the benefit of receiving these messages, but should you wish to withhold consent then please simply decline to sign this form.

If you do provide consent, you may subsequently withdraw your consent at any time by following the opt-out processes shown on our messages or contacting the practice directly.

Please be aware that other messages you may currently receive from us, such as recalls and appointment reminders, are not considered promotional activity and are therefore excluded from being covered by this request for consent. Should you wish to stop receiving these messages then you will need to express your desire to opt-out directly to our reception staff.

We might need to pass your details to trusted third-party communication companies who will deliver these messages to you. Your details will be used solely for delivering this message. We do not pass your details on to other parties for unsolicited marketing purposes. Should you wish to know further details of the third parties involved please refer to the practice's privacy policy.

I consent for my details to be used for the purposes outlined above:

Name _____

Signature _____

Date_____

Please note that this form is only required if you are over 16

Coronavirus (Covid-19) Patient Questionnaire

In light of the rapidly evolving Coronavirus pandemic, and the increasing numbers of UK citizens affected, *Oak Hill Dental and Implant Centre* has implemented a short questionnaire for all patientswho enter our surgery, to ensure the Health and Safety of all employees and patients. We are conducting a simple screening questionnaire below. Your participation is important to help us take precautionary measures to protect you and everyone in this building.

Full Name	
Address	
Contact number	

Self-Declaration by Patient

Have you experienced any cold or flu-like symptoms in the last 14 days (to include fever, cough, sore throat, respiratory illness, difficulty breathing)?	Yes	No
Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days?	Yes	No
Are you, or any person, in your household currently self-isolating due to COVID-19?	Yes	No
Have you returned from any of the countries listed on government website where Coronavirus has been affected within the last 14 days?	Yes	No
Have you, or any person, in your household advised by the NHS that y are classed as a vulnerable person?	Yes	No

Based on the information provided we may need to re-assess how we communicate with you and agree a suitable way we can work together. Should you need to visit us multiple times, we will need to ask you for updated questionnaire each visit.

We recommend that you continue to follow updates and latest advice on how to protect yourself through Government announcements, Public Health England and the NHS.

Sign	
Date	