Creffield Lodge Dental Practice
20 Creffield Road
Colchester, CO3 3JA
01206 572093

Please help us to help you! Please take a few moments to fill in this form. All information is held in strict confidence, and no data is shared with any other organisation.

Surname: .....

First Name: .....

Mr/Mrs/Miss/ or other .....

Date of Birth: .....

Address: .....

.....

.....

Post Code: .....

Telephone: Home .....

Telephone: Work .....

Telephone (Mobile) .....

Email .....

Occupation: .....

How Did You Hear of Us .....

We may wish to contact you to remind you of an appointment or send an account etc. by phone, email, letter or text, are you happy for us to do this?

YES ***NO***

Do you give us permission to discuss your *appointment details* (ie time/date, not details of your treatment) with other family members? (NB you can withdraw this consent at any time).

YES ***NO***

PLEASE TURN OVER!

Present Medical Status

	Yes/No	
1. Are you attending a doctor on a regular basis for any medical condition?	☐ ☐	.....
2. Are you allergic to **any** medicine or tablets? e.g. Penicillin	☐ ☐	.....
3. Are you pregnant?	☐ ☐	.....
4. Have you ever been hospitalised or received prolonged medical treatment in the past, including taking steroids?	☐ ☐	.....
5. Are you taking any tablets or medicine? Please list or let us copy your prescription	☐ ☐	.....
6. Please tick or **tell the dentist** if you are HIV positive	☐ ☐	.....

Your doctor's name and address:

.....

7. Do you suffer from or have you ever suffered from:

	Yes/No		Yes/No
Rheumatic Fever?	☐ ☐	Hepatitis?	☐ ☐
Excessive Bleeding?	☐ ☐	High blood pressure?	☐ ☐
Diabetes?	☐ ☐	Chronic bronchitis or asthma?	☐ ☐
Epilepsy?	☐ ☐	Cold sores?	☐ ☐
Any heart complaint? **(including heart murmur)**	☐ ☐	Any other serious illness? **(please specify)**	☐ ☐

.....

8. Do you smoke? If yes what is your average per day?	☐ ☐	.....
9. Do you drink alcohol? If yes how many units a week?	☐ ☐	.....
10. How long is it since you last received dental treatment?	☐ ☐	.....
11. Are there any other details which your dentist may need to know?	☐ ☐	.....

Completed by **PATIENT** ☐ **GUARDIAN** ☐

SIGNATURE ..... **DATE** .....