BELLEGROVE DENTAL SURGERY CONFIDENTIAL MEDICAL HISTORY /CONSENT FORM

TITLE NAME		DOB:	SEX: M/F
FULL ADDRESS INC POSTCODE:			
PHONE NUMBER: Home:		Work:	
Mobile:		Would you like SMS text reminders? YES / NO	
EMAIL:			
EXPECTANT MOTHER? Yes/ No. If so expected date?		OCCUPATION:	
HOW LONG SINCE YOU LAST RECEIVED DENTAL TREATMENT?			
YOUR DOCTOR'S NAME & ADDRESS: (Telephone number if possible)			
NEXT OF KIN NAME/CONTACT NUMBER:			

	YES	NO	DETAILS
COVID-19:			
Within the last 14 days have YOU had any symptoms of Covid-19? These include 1) a high temperature,2) a new, continuous cough which lasts longer than an hour or 3 or more coughing episodes in 24 hours, or ,3) a loss or change to your sense of smell or taste. If so, what are YOUR symptoms and what date did they start?			
Within the last 14 days has anyone in your HOUSEHOLD had symptoms of (see symptoms above) or tested positive for Covid-19? If so, what are those symptoms and what date did they start?			
Within the last 7 days have you OR someone in your household tested **positive** to? If so, on what date?			
Are you waiting for a Covid-19 test or results?			
Are you considered vulnerable? If so, why?			
CONSENT: I understand that receiving dental treatment means that the UK government's instruction to maintain social distancing of at least 1-2 meters is not achievable during treatment. I understand that Bellegrove Dental Surgery has taken every precaution to make sure my treatment is provided according to strict clinical protocols issued by NHS England. I consent to emergency dental treatment and I consent to the treatment being provided during this current lockdown phase of Covid-19.I am aware that some people do not display symptoms yet may carry Covid-19 and therefore there is a risk of possible transmission during close contact at my appointment .			**Please tick yes or no.**
ARE YOU: 1. Attending/receiving treatment from a doctor, hospital, clinic or specialist?			

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	YES	NO	DETAILS
2. Taking any medicines from a doctor (Tablets, ointments, injections, other) or other regular non-prescribed medicines? Continue overleaf if need be. **If possible, always bring a copy of your prescription for records**			
3. Taking or have you taken steroids in the last two years?			
4. Allergic to any medicines, food or materials?			
HAVE YOU: 1. Ever had Rheumatic Fever?			
2. Had jaundice, liver, kidney disease or hepatitis (which one?)?			
3. Ever been told you have a heart murmur or heart problem, angina, high or low blood pressure?			
4. Had a stroke, heart attack, heart surgery or had a pacemaker fitted?			
5. Ever had a bad reaction to a general or local anaesthetic?			
6. Had a joint replacement or any other implant?			
7. Ever been hospitalised? If "YES", what for and when?			
8. Bled excessively following a tooth extraction, surgery or injury?			
9. Cause to believe you may have been infected with HIV?			
10. Ever had brain surgery?			
11. Had growth hormone treatment before the mid-1980's?			
12. A close relative with Creutzfeldt Jakob Disease?			
DO YOU: 1. Suffer from arthritis?			
2. Suffer from hayfever, eczema or any other allergy?			
3. Suffer from bronchitis, asthma or another chest condition?			
4. Have fainting attacks, giddiness, blackouts or epilepsy?			
5. Have diabetes or does anyone in your immediate family? Also, what type?			
6. Carry any medical warning card? If yes what for?			
7. Ever get cold sores?			
SOCIAL HISTORY: 1. Do you inhale/chew any tobacco or tobacco related products etc...? (Paan, Gutka, THC, Vape or e-cigarettes etc?) If yes, how much do you smoke?			
2. Do you drink any alcohol? If yes, how many units of alcohol do you consume in a typical week?			
FINALLY: Are there any other aspects concerning your health that you think the dentist should know about?			
Are you exempt from NHS charges, if so, what is reason for exemption? **(If your exemption status changes you MUST inform your dentist)**			

Signature ……..	Rechecked Sign …….	Rechecked Sign ……	Rechecked Sign ……	Rechecked Sign …….
Date ……..	Date …….	Date ……..	Date ……..	Date ……..

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