JEVINGTON DENTAL PRACTICE

71 Jevington Way LEE SE12 9NG
0208 851 4949

Patient Information Form

If you have any difficulties completing this form please ask a member of staff for assistance.

Title and Full Name	Date of Birth NHS No:
Address	Home: Mobile: Do you consent to us sending you a text? ☐ Email: Do you consent to us sending you an email? ☐
Occupation if applicable	How did you discover the practice?
Doctors name and address	Previous Dentists name and address
When did you last receive dental treatment?	Are you nervous about treatment ☐
Do you snore at night? ☐ Do you grind your teeth? ☐	Do you have bleeding gums? ☐ Do you have sensitive teeth? ☐ Are you interested in Teeth Whitening? ☐
Do you use a fluoride toothpaste? ☐	Do you smoke? If so how many a day ☐
How many units of alcohol a week do you have? ☐ 1 unit = 1 25ml spirit 2 units = 1 standard glass of wine 3 units = 1 pint of beer	Which of the following do you have each day: Medicines containing sugar ☐ Sugary or Diet fizzy drinks ☐ Sugary treats between meals ☐ Sugar in hot drinks ☐ Sugary snack or hot drink before bedtime ☐
In the case of an emergency please provide the name and contact number of a next of kin	Name: No:

NAME..... DOB:.....

Please complete the following – If you answer YES to any of the following questions please give the details in the box provided.

	Yes	No	Details
Have you had Rheumatic Fever or Chorea?			
Do you have history of any Respiratory Disease, Chronic Bronchitis or Asthma?			
Do you have diabetes, or any family history of diabetes?			
Do you have Epilepsy, blackouts, fainting or giddiness?			
Have you had Hepatitis, Jaundice, Liver or Kidney disease?			
Do you have any blood disorders?			
Do you have high blood pressure or Angina?			
Have you suffered a heart attack or heart disease?			
Do you have a pacemaker or have you had heart surgery?			
Do you suffer with Arthritis?			
Have you had a joint replacement operation?			
Have you taken steroids in the last 2 years?			
Do you suffer from cold sores?			
Are you HIV positive?			
Have you had a blood test recently?			
Has your blood been refused by the transfusion service?			
Have you been hospitalised recently? (last 2 years)			
Do you have any other serious illnesses or related medical conditions?			
Are you currently undergoing any medical treatment?			
Are you currently taking any medication? If you have a copy of a prescription please hand it to the receptionist to photocopy.			
Are you allergic to any medicines or tablets?			
Have you had an allergic reaction to local or general Anaesthetic?			
Do you have any allergies?			
Are you pregnant? If yes when is the baby due?			
Do you use recreational drugs?			

Sign & Date 1st visit..... Sign & Date: 2nd visit.....……

Sign & Date 3rd visit……..... Sign & Date 4th visit……

Sign & Date 5th visit ..... Sign & Date 6th visit .....