CONFIDENTIAL MEDICAL HISTORY FORM

PERSONAL DETAILS

Surname:	
First Name:	
Title:	
Gender:	
Date of Birth:	Current Age:
Address:	
Post Code:	
Home Telephone No:	
Work Telephone No:	
Mobile Telephone No:	
Email:	
Occupation:	

DOCTORS DETAILS

Doctors Name:	
Practice Name:	
Practice Address:	
Practice Post Code:	
Practice Telephone No:	
Practice Email Address:	

DO YOU PAY FOR DENTAL TREATMENT

YES *(if yes tick and skip to the next section)*		**NO** *(if NO please give full details below)*	
Patient Under 18			
Aged 18 and in full time education			
Full Remission HC2 Certificate			
Partial Remission HC3 Certificate			
Expectant Mother (Baby Due Date)			
Nursing Mother (Baby Birth Date)			
Prisoner			
Other type of benefit / exemption - please give full details			

EVIDENCE PROVIDED

YES		**NO**	
Type of Certificate / Card			
Name On Certificate / Card			
Certificate / Card Number			
HC3 Certificate amount to Pay is	£		

ETHNIC GROUP

Already Given As:	
White British	
White Other	
White & Black Caribbean	
White & Black Asian	
White & Asian	
Other Mixed Background	
Asian / Asian British Indian	
Asian / Asian British Pakistani	
Asian / Asian British Bangladeshi	
Other Asian Background	
Black / Black British Caribbean	
Black or Black British African	
Other Black Background	
Chinese	
Any Other Ethnic Group	
Patient Declined	

NHS CHARGES AND PAYMENTS

If you pay NHS charges, you will pay one of the Government fixed charges. (Posters displayed in waiting areas, on clipboard and available from reception).

Please be notified that the NHS carries out routine checks on all dental treatment claims, including claims where evidence of entitlement is shown to the dental practice, if you are found to have wrongly claimed for free or reduced dental costs, the NHS will take further action and you will have to pay a penalty charge of £100 and pay back ANY costs of the dental treatment you have received. **Please DO NOT MAKE ANY FALSE ALLEGATIONS - Chopra & Associates accepts NO LIABILITY FOR FALSE INFORMATION SUPPLIED TO US.**

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE OF THIS FORM

MEDICAL HISTORY

	Question	NO	YES - Please give details
1	Do you smoke? (if yes how many per day)		
2	Do you drink? (if yes how many units per week)		
3	Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?		
4	Are you taking any medicines, pills, tablets or any other form of drugs?		
5	Are you allergic to any medicines, foods or materials?		
6	Have you had rheumatic fever or chorea (St Vitas Dance)?		
7	Had jaundice, liver, kidney disease or hepatitis?		
8	Ever been told you have a heart murmur or heart problem, angina, high/low blood pressure or heart attack?		
9	Ever had your blood refused by the blood transfusion service?		
10	Have you ever had a joint replacement?		
11	Do you take or have you taken steroids in the last two years?		
12	Have you been hospitalised? If yes what for and when.		
13	Do you have arthritis?		
14	Do you have a pacemaker have had any form of heart surgery?		
15	Do you suffer from bronchitis, asthma or any other chest condition?		
16	Do you have fainting attacks, giddiness, blackouts / epilepsy?		
17	Do you have diabetes, or does any member of your family?		
18	Do you bruise easily, or after a tooth extraction, surgery or injury, have you bled so as to cause you to be worried?		
19	Do you carry a warning card?		
20	Are there any aspects concerning your health that you think the dentist should know about?		
21	Are you receiving treatment from any other dental related company?		
22	Are you pregnant?		Baby Due Date:
23	Are you a mother of a child under 1 years of age?		Baby Birth Date:
24	Have you received a Patient Information Leaflet?		

COMPLIANCE WITH OUR POLICIES

Upon completing and signing this form, you are confirming that you have viewed or have been given a Practice Information Leaflet (PIL) and that you are agreeing to comply with our Practice Policies, as set out in this leaflet. Failure to comply will result in you not being seen and/or treated at any of our practices.

FORM COMPLETED BY (please circle and sign) **SELF / PARENT / GUARDIAN** (if under 16)

Signature..... Dated .....

Please note that if any of your details change please inform the surgery at your earliest convenience.

THIS SECTION IS FOR COMPLETION BY DENTAL STAFF ONLY

Dental Nurse: ..... Dental Surgeon: .....