Patient Details					
Title		First Name		DOB	
Family Name				Sex M/F	
Care Home Address & unit/house/floor					
Care Home 'Phone					
GP address & Telephone					

Next of Kin Details (required for permission and bill payment)	
Next of Kin name	
Address, & Telephone	

Benefits	
I receive no benefits	Pension Credit Guarantee Credit
HC2 HC3	Income Support

Medical History			
	Yes	No	Comments
Are you taking any prescribed medications of ANY sort? (please list below)			
Do you have any allergies e.g. penicillin, latex?			
Have you had/have hepatitis/jaundice?			
Are you HIV positive, had an HIV test or have a high risk lifestyle for HIV?			
Are you currently receiving any medical treatment?			
Do you have heart problems like angina, high blood pressure or a previous heart attack?			
Do you have any breathing problems?			
Do you suffer from epilepsy, fainting or blackouts?			
Do you or any member of your family suffer from diabetes?			
Do you bleed excessively?			
Do you have any problems with local or general anaesthetics?			
Have you been in hospital recently? If so what for…….?			
Do you smoke tobacco or use tobacco products?			
Do you use recreational drugs?			
What is your alcohol intake (units per week)?			
Any other information you think your dentist should know?			
Is there a Do Not Resuscitate mandate?			
Is there an AWI certificate?			
Reason for AWI certificate?			

Please enclose list of medications below (or continue on reverse)
[MARS sheets may be used]:

Please sign and date this form below

DATE:……..

SIGNATURE:……..
(patient / carer / key worker /guardian / family member / PoA)