SPECIALIST DENTAL SERVICES, 7 Wimpole Street, London, W1G 9SN		
Mr/Mrs/Miss/Ms/Other	Surname:	
Forename:	Date of Birth:	
Address:		
Postcode:	Email:	
Tel: H -	W -	M -
GP Name & Address:		
Introduced by:	Last dental visit:	

We offer an appointment reminder service by text and/or email. Please tick ___ if you do NOT wish to receive reminders or correspondence by text/email. We do NOT disclose your information to any third parties

	Y / N	Details
Are you currently taking any prescribed medicines?		
Are you currently taking or have you taken in the past Bisphosphonates? e.g. Foxamax/Didronel/Zometa		
Do you suffer from any allergies? E.g. Penicillin /latex /rubber		
Do you suffer from fainting attacks/giddiness/blackouts or epilepsy?		
Do you suffer from Asthma, bronchitis or any other chest condition?		
Do you suffer from heart problems, angina, high or low blood pressure or ever had a stroke?		
Are you or is anyone in your family Diabetic?		
Do you suffer from Arthritis?		
Do you suffer from bruising or persistent bleeding following injury/tooth extraction or surgery?		
Do you suffer from any infectious diseases? e.g. HIV /Hepatitis		
Have you ever had liver disease? e.g. jaundice / Kidney disease?		
Have you ever had any other serious illnesses?		
Have you ever had your blood refused by the Blood Transfusion Service?		
Have you ever had a bad reaction to a local or general anaesthetic?		
Have you ever been hospitalized?		
Do you drink more than 21 units of alcohol a week?		
Do you smoke? If yes how many per day:		
Do you chew tobacco, pan, use gutkha or supari?		
Is there any other information which has not been asked on this form that you feel the dentist should know about?		

Do you have any Medical and/or Dental Insurance e.g. BUPA? Yes/No

Details:……

SIGNED:
(Delete as appropriate)……Patient/Parent/Guardian
DATE: