LOGANHOLME DENTAL CENTRE

SURNAME_____GIVEN NAMES_____MR/MRS/MISS/MS

PRIVATE ADDRESS_____

_____POST CODE_____DOB_____

PHONE_____ MOBILE_____

EMAIL ADDRESS _____

ARE YOU IN A PRIVATE HEALTH FUND THAT COVERS YOU FOR DENTAL TREATMENT YES/NO_____

MEDICAL AND DENTAL HISTORY

A HEART CONDITION	YES / NO
HIGH BLOOD PRESSURE	YES / NO
EXCESSIVE BLEEDING	YES / NO
RHEUMATIC FEVER	YES / NO
DIABETES	YES / NO
THYROID DISORDER	YES / NO
EPILEPSY	YES / NO
ASTHMA	YES / NO

ANY OTHER ILLNESS : PLEASE STATE YES / NO _____

IS THERE A POSSIBILITY THAT YOU COULD BE PREGNANT YES / NO

DO YOU REQUIRE ANTIBIOTIC COVER FOR ANY DENTAL TREATMENT (HEART ISSUES/JOINT REPLACEMENT) YES / NO

ARE YOU ALLERGIC TO ANY DRUGS OR MEDICINES (example : PENICILLIN, ANAESTHETICS) YES / NO

IF YES_____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS – please list all prescription medications and vitamins

(example fish oil etc) YES / NO IF YES_____

_____

ARE YOU A SMOKER AND IF SO HOW MANY CIGARETTES PER DAY _____ YES / NO

WHO IS YOUR MEDICAL DOCTOR_____

HAVE YOU EVER HAD HEPATITIS OR BEEN ADVISED YOU MAY BE A CARRIER YES / NO

IS THERE ANY REASON FOR YOU TO SUSPECT YOU ARE AT RISK OF HAVING AIDS/HIV OR ANY DISEASE

RELATING TO AIDS / HIV YES / NO

HOW LONG IS IT SINCE YOUR LAST COURSE OF DENTAL TREATMENT_____

SIGNATURE_____DATE_____

PAYMENT OF FEES AT EACH VISIT IS REQUIRED

LOGANHOLME DENTAL PRIVACY POLICY – THE INFORMATION WE COLLECT FROM THIS FORM WE USE TO PERSONALISE YOUR EXPERIENCE, BY RESPONDING TO YOUR REQUESTS, SUPPORT & MEDICAL NEEDS. WE WILL SEND TO YOU REGULAR RECALL LETTERS USING THIS INFORMATION EITHER BY MAIL/TEXT OR EMAIL. YOUR INFORMATION WILL NOT BE SOLD, EXCHANGED, TRANSFERED OR GIVEN TO ANY OTHER COMPANY FOR ANY REASON WITHOUT YOUR CONSENT. WE MAY RELEASE YOUR INFORMATION WHEN BELIEVED TO BE APPROPRIATE TO COMPLY WITH THE LAW TO PROTECT OURS OR OTHERS RIGHTS, PROPERTY OR SAFETY. MODIFICATIONS TO THIS POLICY WILL BE MADE AS REQUIRED. THIS POLICY LAST MODIFIED 31/08/2016