



PRIVATE CHILD/UNDER 18 - Confidential Medical History

Your dentist needs to know of any problems which may affect your treatment. Please answer the questions as accurately as possible. To be completed by the Patient, Parent, or Guardian.

TITLE:	FIRST NAME:	SURNAME:
SEX:	DATE OF BIRTH	POSTCODE:
ADDRESS:		
Home Number:	Mobile Number:	Email:
Are you in receipt of any exemption: YES / NO		
If Yes, which one?		

Doctors Information		
Name of Doctors:		
Address:		
Telephone Number:		
Are you?	Yes / No	Give details
Expectant Mother?		<u>Due date:</u>
Receiving treatment from a doctor, hospital or clinic?		
Taking any medication?		<u>Please put medication in this box:</u>
Carrying a warning card?		
Allergic to any medicines? Including Chlorhexidine		
Have you had/being treated for?		
Hepatitis? Recent jaundice?		
Infective Endocarditis, Heart Valve Replacement or Shunt/Conduit		
High Blood Pressure		
Heart complaint e.g. Angina, Stroke, Attack, murmur?		
Are you/have you been treated for Osteoporosis?		
Bleed excessively from cuts or if you have a tooth extracted?		
Bronchitis, Asthma, or any other chest condition?		
Diabetes?		
Suffer from Epilepsy, Fainting Attacks or Blackouts?		
Any other serious illness or operations?		

Frequent headaches and associated jaw pain?		
Is there any chance that you have become infected with HIV?		
Do you suffer from any issues such as: ADHD/Autism/Special Needs, etc (Please state them in the details box.		
Practice dental chairs have a weight limit, this is for the safety of our patients and our staff - Please tell us your weight in KG.		<u>Please put KG in weight in this box:</u>
When was your last dental visit:		
Do you smoke (This includes vaping): YES / NO		
Have you smoked in the past: YES / NO	Quantity:	
Do you drink alcohol: YES / NO		
Number of units per week:		

<u>Next of kin emergency contact</u>		
TITLE:	FIRST NAME:	SURNAME:
RELATIONSHIP WITH NEXT OF KIN:	CONTACT NUMBER:	POSTCODE:
ADDRESS:		

Please confirm how you would prefer for us, Beechcroft Dental Practice, to contact you. You can update your preferences at any time. If you would like to know more about our Data Protection Policy, please ask for a copy.

Reminder phone calls:

- Mobile
- Landline
- Letter
- Email _____

If signing on behalf of someone else, please state the full **name** and **relationship to the patient**.

Signature: _

Date:

Please be aware that if you Fail to Attend 3 appointments then you will be de-registered from the practice. Short notice cancellations will also be taken into account for 3 Appointments. If you fail to attend your first appointment at the practice as a new patient, then you will be de-registered.

We require at the least a 24 hour notice period for any appointment cancellations.

Private appointments - require a £20.00 deposit for all appointments to be made. No deposit means, no appointment can be booked

Beechcroft Dental Practice
New Costessey, Norwich
NR5 0RS
Phone: 01603 747651
Email: Reception.beechcroftdental@outlook.com