**CONFIDENTIAL MEDICAL HISTORY FORM**

To obtain the safest and best treatment your dentist needs to know of any problems which may affect your treatment. All information will be kept strictly confidential.

|  |
| --- |
| Title First Name Family Name(Mr/Mrs/Miss etc.) |
| D.O.B | Occupation | Email |
| Address POST CODE  |
| Telephone Home Work Mobile |
| Pregnant/Possibly Pregnant? Yes / No How long since you last received dental treatment? |
| **Are you currently:**  | **Yes** | **No** | **Details** |
| Attending or receiving treatment from a doctor, clinic, hospital or specialist? |  |  |  |
| Taking any medicines (tablets, creams, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)? |  |  |  |
| Carrying a medical warning card? |  |  |  |
| **Have you ever suffered from:** |  |  |  |
| Allergies to any medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods? |  |  |  |
| Bronchitis, asthma or other chest condition? |  |  |  |
| Fainting attacks, giddiness, blackouts or epilepsy? |  |  |  |
| Heart problems, angina, blood pressure problems or stroke? |  |  |  |
| Diabetes (or does anyone in your family)? |  |  |  |
| Bone or Joint Disease? |  |  |  |
| Bruising or persistent bleeding following injury, tooth extraction or surgery? |  |  |  |
| Liver Disease (e.g. jaundice, hepatitis) or kidney disease? |  |  |  |
| Any other serious illness, HIV, Hep B/C or other infectious disease? |  |  |  |
| Having your blood refused by the Blood Transfusion Service? |  |  |  |
| Had any blood tests and inoculations? |  |  |  |
| A bad reaction to general or local anaesthetic? |  |  |  |
| Being hospitalised? If "Yes" for what and when? |  |  |  |
| Heart surgery? |  |  |  |
| **Do you:** |  |  | **Times Per Day** |
| Smoke or chew any tobacco products now or in the past? |  |  |  |
| Drink alcohol? (A unit is half a pint of lager, a single measure of spirits or a single glass of wine/aperitif) |  |  |  **How many units:**  |

During a medical emergency where I am unable to speak for myself, I hereby give my permission to the staff to contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name) on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (telephone number)

Are there any aspects concerning your health that you think the dentist should know about such as self-prescribed medicines (e.g. aspirin) or any disabilities you may have?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Self/Guardian Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| How did you hear about us and/or whom may we thank for referring you? |
| Your Doctor’s name, address and telephone number |

**GDPR CONSENT**

We would like to send you exclusive offers and the latest info from the company by email, text or phone. We will always treat your personal details with utmost care. Please tick the box to confirm that you are happy for us to do so

YES NO

If you prefer not to receive reminders, please email the practice on reception@advanceddentistry.co.uk

**CLINICAL PHOTOGRAPHY**

At the Windsor Centre for Advanced Dentistry we will need to take photographs of your face, mouth and teeth. We may also take video recordings to document the dynamic movements of your teeth in function such as chewing, talking and smiling, or to document treatment procedures. The photographs and videos may be used for:

* Clinical purposes relating to the evaluation, documentation and planning of your treatment. This includes before, during and after any treatment we carry out and this documentation will be kept with your confidential dental records and by the individual dentists.
* For teaching purposes and demonstrating clinical techniques for Dental Care Professionals at educational courses, online professional educational forums, scientific lectures, symposia/meetings.
* In papers published in scientific journals, books or online educational forums
* For practice marketing purposes (e.g. our website and social media)

In all of the above the photographs and videos will be made anonymous when used for any purpose not directly related to your dental care. In the main, the images will be of the teeth and gums. However, if a facial image is used the image will be made anonymous by obliterating the eye area of the photographs so that patients cannot be personally identified when they are used in lectures or publications.

*We will not use facial images in any marketing material without the express permission of the patient.*

**CONSENT FOR THE USE OF PHOTOGRAPHS/VIDEOS**

I agree to the photographs/videos being taken by a dentist at Windsor Centre for Advance Dentistry and consent to their use for the purposes described above. I understand that their use will be in accordance with the 1998 Data Protection Act and that the photographs will be made anonymous when used for any purpose not directly related to my dental care. I understand that involves obliterating the eye area of the photographs so that I cannot be personally identified when they are used in lectures or publications.

If, for whatever reason, the photograph cannot be adapted to preserve my identity, Windsor Centre for Advanced Dentistry will contact me to explain the reasons and seek my consent for use of the photographs. I understand that the photographs will not be used in these circumstances unless my consent is obtained.

Signed by patient or guardian ……………………………………………………… Date: ………………………

Print Name: ……………………………………………………………