Office use only	input	checked	scanned

PLEASE COMPLETE IN BLOCK CAPITALS

At Bay House Dental Practice, we take great care with all the Personal Data we hold, to ensure we comply with best professional practice and with the law. For a full copy of our Data Privacy Notice please ask at reception.

Like all dentists, we ask patients for information about their general health to help us to treat them safely. All information will be kept strictly confidential.

NHS No._____ Title_____Surname_____

Forenames _____ Date of birth _____

Address _____

_____ Postcode _____

Preferred Contact Number/Numbers_____

*Email address*_____

Emergency contact number (next of kin)_____

Occupation _____Date of last dental treatment _____

Doctor's name _____ _____Doctor's telephone_____

Doctor's address _____

ARE YOU CURRENTLY	**YES**	**NO**	**GIVE DETAILS**
Pregnant			
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)? Name/Names of Medication PLEASE WRITE IN BLOCK CAPITALS.			
Carrying a medical warning card?			

Do you consume alcohol?	If YES, how many units per week?		NO	IN THE PAST
Do you smoke any tobacco products?	If YES, how many per day?		NO	
Do you chew tobacco, pan, use gutkha or supari	YES		NO	
Would you like help to stop smoking?	YES	NO	If so please ask your dentist or Hygienist for information.	

Smoking and or drinking alcohol can seriously affect your health and your oral health **P.T.O**

DO YOU SUFFER FROM	**YES**	**NO**	**GIVE DETAILS**
Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods?			
Hay fever or eczema?			
Bronchitis, asthma or other chest condition?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart problems, angina, blood pressure problems, or stroke?			
Diabetes (or does anyone in your family)?			
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases including HIV, Hepatitis and Herpes (cold sores)			
DID YOU, AS A CHILD OR SINCE, HAVE:	**YES**	**NO**	**GIVE DETAILS**
Rheumatic fever or chorea?			
Liver disease (e.g. jaundice, hepatitis) or Kidney disease?			
Any other serious illness?			
A bad reaction to general or local anaesthetic?			
A joint replacement or other implant?			
Undergone hospitalisation that may affect Your dental care?			
Heart surgery, Heart Murmur, Heart Valve Replacement, a pacemaker or shunt?			
Brain surgery?			

Following a number of recent Health and Safety issues and advice from the manufacturers and our insurers, we have to inform all our patients that there is a weight limit on our dental chairs of 140kg. If you believe you weigh above this amount please let your dentist know as we will not be able to lie you flat in the chair to proceed with any treatment. Whilst we appreciate that this is a delicate issue, should the chair fail and injure you then we would not be covered by our insurers. Please put *YES* in the box on the right if you think you weigh more than 140kg (22 stone/308lb) and answer *NO* if you are under this weight. *An answer is required.*	

PLEASE GIVE ANY OTHER DETAILS WHICH YOUR DENTIST MIGHT NEED TO KNOW ABOUT, SUCH AS SELF-PRESCRIBED MEDICINES (eg ASPIRIN)

FORM COMPLETED BY (Please tick) Self ☐ Parent ☐ Guardian ☐ Relationship _____

SIGNATURE _____ Date _____

Office use only	input	checked	scanned

BAY HOUSE
DENTAL PRACTICE

PLEASE COMPLETE IN BLOCK CAPITALS

Patient Covid -19 Status

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Title_____ Surname_____Forename_____

Date of birth _____

	YES	NO	GIVE DETAILS
Do you currently have Covid 19?			
Are you currently experiencing any of following symptoms? Fever, Cough, Breathing Difficulties, Flu, Lack of Taste/Smell, Skin Rash, Diarrhoea			
Have you had any of above symptoms in **last month?**			
Have you had Covid 19?			
If you answer Yes, when did you have it?			
Have you had a Covid -19 test?			
If So, When Were You Tested?			
Have you been in contact with anybody with Covid19?			
Are you classed as a vulnerable person and been advised to Shield by the health authorities/GP?			
Are you or anyone in your household self-isolating?			
Have you had any contact with anyone placed in quarantine, either self-imposed or organised by the health authorities, in the last month due to travel?			
Have you had a covid-19 anti-body test?			
If yes do you have documentation of the result? (please provide copy)			

FORM COMPLETED BY (Please tick) Self ☐ Parent ☐ Guardian ☐ Relationship _____

SIGNATURE _____ Date _____