JacMe Oral Care

New Patient Medical History

Any questions please ask at reception.

Title: _____Surname: _____
First name: _____Date of birth: _____

Full Address: _____
Postcode:_____Occupation:_____
Telephone:_____Telephone (work):_____
Mobile:_____ E-Mail:_____

Doctor's name: _____
Doctor`s address: _____

In order to evaluate dental health thoroughly, please complete the following questionnaire:

Dental History

What has prompted you to make an appointment: _____
How did you hear about the practice: _____
How long is it since your last dental examination: _____

Do you currently have dental pain: Yes / No
Has fear of dental treatment kept you from regular dental appointments Yes / No
Were you satisfied with previous dental treatment: Yes / No
If you have any more information about your dental history please give details:
_____

Medical History

DO YOU SUFFER FROM THE FOLLOWING?

Heart trouble	**Yes / No**	**Do you smoke/vape (please circle)**	**Yes / No**
Rheumatic Fever	**Yes / No**	**High or low blood pressure (please circle)**	**Yes / No**
Diabetes	**Yes / No**	**Epilepsy**	**Yes / No**
Hepatitis A, B OR C	**Yes / No**	**Arthritis**	**Yes / No**
Asthma	**Yes / No**	**Jaundice, liver or kidney disease**	**Yes / No**

HIV positive? Yes / No **Do you have a pacemaker Yes / No**

Do you have fainting attacks? Yes / No **Do you carry a warning card? Yes / No**

Have you ever had your blood refused by the Blood Transfusion Service? Yes / No

Have you ever had a bad reaction to local or general anaesthetic? Yes / No

Have you ever had a joint replacement or other implant? Yes / No

Are you currently under the care of your doctor or taking prescribed medication **Yes / No**
Do you drink alcohol? If so how many units a day / week? **Yes / No** **Units:_____**
Have you ever suffered or are suffering from tuberculosis? **Yes / No**

Do you think there are any aspects concerning your health you think we should know about?Yes / No

If Yes please give details: _____

Please give details of any prescribed medication you are taking

_____
Are you allergic to penicillin? Yes / No **Any other allergies? _____**
Women: are you pregnant: Yes / No **Due date: _____**
Any other medical problems? _____

_____

<u>Emergency contact</u>

During a medical emergency where I am unable to speak for myself, I hereby give my permission for the staff to contact (Name) _____on _____ (Telephone Number).

<u>Claim For Free Or Reduced Costs On The NHS Dental Services</u>

If you are entitled to receive free or reduced NHS dental treatment please make sure you check what exemption you receive before you attend the practice. Incorrect claims for free or reduced NHS dental services will result in a penalty charge of up to £100, in addition to costs of NHS dental services.

Signature: _____ Date: _____

Privacy notice: Here at the practice we take your privacy seriously, and will only use your personal information to provide our treatment and services to you and to administer your account. We may share your information with our trusted partners to help us deliver this service for you, but they do not use it for anything else. We will never sell, publish or share your information with any unauthorised person or group.

Statement of Payment Policy: JacMe Oral Care (JOC) charges patients according to NHS charges. Patients on valid exemptions are entitled to free or reduced dental treatment available on NHS. JOC requires full payment after the highest band treatment has been started. Any unpaid debts will be claimed back through collection process.

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