Please complete in capital letters 

**Confidential Medical History Form**

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| **Contact Details** |
| Surname: | Title: |
| Forenames: | Date of Birth |
| Address: | I give permission to be contacted on the telephone number below: **please provide a mobile number**   |
| Email:  |
| Occupation: mum |
| Do you require the stairlift ?(requirement under 120kgs)WHERE DID YOU HEAR ABOUT US? | GP Details --------------------------------------------------------------------- |
|  | yes | no | If yes please give details |
| Are you currently receiving treatment from your GP or hospital  |  |  |  |
| Do you experience any heart problems or angina |  |  |  |
| Do you suffer from any chest pains |  |  |  |
| Are you taking any medication/tablets/ **please list** |  |  |  |
| Are you recovering from a GA/Op/hospital |  |  |  |
| Are you Diabetic |  |  |  |
| HPV- Human Papillomavirus |  |  |  |
| Do you suffer from any serious illness or condition |  |  |  |
| Do you have any known allergies |  |  |  |
| Do you suffer from chronic Bronchitis, Asthma or any other respiratory disease |  |  |  |
| Had epilepsy, blackouts, giddiness or fainting |  |  |  |
| Had hepatitis, Jaundice, Liver or Kidney disease |  |  |  |
| Had excessive bleeding and/or bleeding disorders |  |  |  |
| Do you have a **pacemaker** fitted |  |  |  |
| Suffer from Arthritis |  |  |  |
| Ever undergone a joint replacement operation |  |  |  |
| Received steroid therapy in the past two years |  |  |  |

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|  **Do you**  |
|  | **yes** | **no** | If yes please give details |
| Do you suffer from herpes or cold sores |  |  |  |
| Are you HIV positive |  |  |  |
| Family history of mouth cancer  |  |  |  |
| Had an allergic reaction to either local or general anaesthetic |  |  |  |
| How many units of alcohol per week |  |  |   |
| How many cigarettes per week |  |  |  |
| Chewing tobacco |  |  |  |
| Have you ever had SEPSIS? |  |  |  |
| **Female patients** |
|  | **yes** | **no** |  |
| Are you a mother of a child under 12 months |  |  |  |
| Are you expecting a baby,  |  |  | If yes, please specify the due date: |

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| **Exemption from Dental charges** |
| Are you under 18 years |  |
| Are you 18 years and in full time education(please give details of the school/college) |  |
| Are you named on a valid HC2 Exemption certificate |  |
| **Do you receive any of the following: PROOF WILL BE ASKED FOR/REQUIRED** |
| Pension Credit | Income Support/ESA | Tax Credit | Universal Credit |

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|  C**OVID-19 ASSESSMENT**  |
| **Do you have any of the following symptoms of Covid 19:** |
|  | **Yes** | **No** |  |
| New continuous cough? |  |  |  |
| High Temperature above 37.8? |  |  |  |
| Change in taste or smell? |  |  |   |
| Sore Throat? |  |  |  |
| Have you been diagnosed or had Covid-19? |  |  |  |
| Are you vulnerable or shielding? |  |  |  |
| Would you consider yourself high risk? |  |  |  |
| Are you currently living in a care home? |  |  |  |
| Is your background ethnic |  |  |  |
| Were you born outside of the UK or Ireland |  |  |  |

 **NHS Patients Under NHS regulations, we are unable to charge NHS patients who fail to attend for their initial appointments or who cancel at short notice (less than 24 hours notice is insufficient notice). A patient who fails to attend their new patient appointments or cancels at short notice, may not be offered any further appointments at this practice, but you may seek another NHS practice elsewhere. Please sign below to acknowledge this statement.**

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| **Declaration** |
| Completed by (please circle): Self/Guardian; I hereby apply to become a patient of Lighthouse Dental Practice . I undertake to settle all fees when due. I understand that interest may be paid on overdue accounts and that seriously overdue accounts may incur extra fees. Signature …………………………………………………………Date …………………………. |