Please give any other details which your dentist might need to know about, such as self-prescribed medicines (eg. aspirin) or any disabilities you may have.

Completed by (please tick) self ☐ parent ☐ guardian ☐

Patient signature _____ Date _____

Dentist signature _____ Date _____

Chester Road Dental Care may have information that we would like to contact you about. Please indicate how you would prefer to hear from us (you can tick more than one box):

☐ Mail ☐ Phone ☐ Email ☐ Text/SMS

You will only ever receive communication from Chester Road Dental Care.

Are you interested in your dentist discussing with you about:

☐ Tooth whitening

☐ Orthodontics

☐ Other, please specify _____

CHESTER ROAD
DENTAL CARE

Confidential Patient Registration & Medical History Form

We ask you for information about your general health to help us treat you safely. Please write your contact details below, answer the health questions and then sign the form on the back page. We will use this form at later visits to discuss any change in your general health. All information will be kept strictly confidential by the people caring for you.

Title: | Last name:

First name:

Date of birth: DD / MM / YYYY | Sex: Male ☐ Female ☐

Address:

Postcode:

Telephone number (home): Mobile number:

Email:

Occupation/School:

What is your ethnic group? **Please choose ONE selection from this list to indicate your ethnic group:**

- ☐ Patient declined
- ☐ White British
- ☐ White & Black African
- ☐ Asian or Asian British Pakistani
- ☐ Black or Black British African
- ☐ White Irish
- ☐ White & Asian
- ☐ Asian or Asian British Bangladeshi
- ☐ Other Black background
- ☐ Other white background
- ☐ Other mixed background
- ☐ Other Asian background
- ☐ Chinese
- ☐ White & Black Caribbean
- ☐ Asian or Asian British Indian
- ☐ Black or Black British Caribbean
- ☐ Any other ethnic group

During a medical emergency where I am unable to speak for myself, I hereby give my permission for the staff to contact: Name:

Telephone number: | Relationship to you:

Doctor's details

Doctor's name: | Telephone number:

Address:

Postcode:

Are you currently	yes / no	give details
Receiving treatment from a doctor, hospital or clinic?	☐ ☐	Please give details:
Taking any prescribed medicines (eg tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?	☐ ☐	Please list:
Carrying a medical warning card? (eg. yellow book, pacemaker, anticoagulant, bisphosphonates)	☐ ☐	
Pregnant or possibly pregnant?	☐ ☐	No. of weeks _____

Have you ever had	yes / no	give details
Allergies to medicines (eg penicillin), substances (eg latex/rubber) or foods?	☐ ☐	
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)?	☐ ☐	
Bone or joint disease?	☐ ☐	
Bruising or persistent bleeding following injury, tooth extraction or surgery?	☐ ☐	
Liver disease (eg. jaundice, hepatitis) or kidney disease?	☐ ☐	
Any other serious illness or infectious disease?	☐ ☐	

Have you ever had	yes / no	give details
Blood refused by the Blood Transfusion Service?	☐ ☐	
A bad reaction to general or local anaesthetic?	☐ ☐	
Treatment that required you to be in hospital?	☐ ☐	
Heart surgery?	☐ ☐	

Alcohol

How many units of alcohol do you drink per week? (A unit is half a pint of lager, a single measure of spirits or a single glass of wine/aperitif).	_____ units per week

Smoking	yes / no / in the past	
Do you smoke any tobacco products now (or did you in the past)?	☐ ☐ ☐	_____ times per day
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)?	☐ ☐ ☐	_____ times per day

Habits	yes / no / in the past
High sugar frequency	☐ ☐ ☐
Lots of fizzy/acidic drinks	☐ ☐ ☐
Recreational drugs	☐ ☐ ☐