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| **Patient Details** |
| Title |  | First Name |  | DOB |  |
| Family Name |  | Sex M/F |  |
| Care Home Address & unit/house/floor |  |
| Care Home ‘Phone |  |
| GP address & Telephone |  |

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| **Next of Kin Details** (required for permission and bill payment) |
| Next of Kin name |  |
| Address, & Telephone |  |

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| **Benefits** |
| I receive no benefits | Pension Credit Guarantee Credit |
| HC2 HC3 | Income Support |

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| **Medical History** |
|  | Yes | No | Comments |
| Are you taking any prescribed medications of ANY sort? (please list below) |  |  |  |
| Do you have any allergies e.g. penicillin, latex? |  |  |  |
| Have you had/have hepatitis/jaundice? |  |  |  |
| Are you HIV positive, had an HIV test or have a high risk lifestyle for HIV? |  |  |  |
| Are you currently receiving any medical treatment? |  |  |  |
| Do you have heart problems like angina, high blood pressure or a previous heart attack? |  |  |  |
| Do you have any breathing problems? |  |  |  |
| Do you suffer from epilepsy, fainting or blackouts? |  |  |  |
| Do you or any member of your family suffer from diabetes? |  |  |  |
| Do you bleed excessively? |  |  |  |
| Do you have any problems with local or general anaesthetics? |  |  |  |
| Have you been in hospital recently? If so what for…….? |  |  |  |
| Do you smoke tobacco or use tobacco products? |  |  |  |
| Do you use recreational drugs? |  |  |  |
| What is your alcohol intake (units per week)? |  |  |  |
| Any other information you think your dentist should know? |  |  |  |
| Is there a Do Not Resuscitate mandate? |  |  |  |
| Is there an AWI certificate? |  |  |  |
| Reason for AWI certificate? |  |
| Please enclose list of medications below (or continue on reverse) **[MARS sheets may be used]**: |

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| Please sign and date this form below**DATE**:……………………………………………………………..**SIGNATURE**:…………………………………………………….(patient / carer / key worker /guardian / family member / PoA) |