**Patient details:**

|  |  |
| --- | --- |
| **Full name** |  |
| **Date of birth** |  |
| **Gender** |  |
| **Address and post code** |  |
| **Telephone Number**  **Home & Mobile** |  |
| **NHS number (if known)** |  |

**Additional information:**

|  |  |  |
| --- | --- | --- |
| **Translator required?** | Yes | No |
| **Wheelchair user or requires assistance with mobility?** | Yes | No |
| **Any other details which may help the dental team to offer the best service.** |  | |

**Oral health information:**

Diet & toothbrushing routine –

What are your daily dietary habits, do you favour sweet over savoury (please note normal drinks consumed & daily meal habits)?

Brushing routine, do you brush daily? (please circle the appropriate answer)

Yes No

Do you brush once daily, if so am or pm Do you brush twice daily, yes or no

Please circle the items you use for brushing your teeth

Electric toothbrush Manual toothbrush Fluoride toothpaste Prescribed toothpaste

**Social information:**

I provide permission for you to see my child at their school to carry out a dental examination.

Name in capitals: Signature:

Relationship to child:

Do you have carers or keyworker - Yes No N/A

NOK /POA –

**Are you currently Yes No Give details**

|  |  |  |  |
| --- | --- | --- | --- |
| Taking any prescribed medicines? |  |  |  |
| Taking any self-prescribed medicines/drugs? (including painkillers) |  |  |  |
| Receiving treatment from a specialist, hospital or clinic? |  |  |  |
| Under investigation for any conditions? (e.g. blood tests) |  |  |  |
| Under review following previous serious conditions/treatments? |  |  |  |
| Taking or have taken steroids in the last two years? |  |  |  |
| Carry a medical warning card or bracelet? |  |  |  |
| Pregnant, possibly pregnant or breastfeeding? |  |  | **Due date:** |
| Under the care of any community health teams (e.g. mental health, speech and language therapy)? |  |  |  |

**Have you ever had Yes No Give details**

|  |  |  |  |
| --- | --- | --- | --- |
| Any allergies (including, medicines, latex, plasters, food, jewellery etc) |  |  |  |
| Heart problems / angina / high or low blood pressure / endocarditis / valve disease, heart surgery or a pacemaker? |  |  |  |
| Stroke / transient ischaemic attack? |  |  |  |
| Bronchitis / asthma / tuberculosis / chronic obstructive pulmonary disease / sleep apnoea or other breathing condition? |  |  |  |
| Epilepsy, multiple sclerosis, parkinson’s, or other neurological disorders? |  |  |  |
| Problems with blood vessels? (e.g. deep vein thrombosis / blood clots / pulmonary embolism) |  |  |  |
| Persistent bleeding or bruising after injury, tooth  extraction & surgery? |  |  |  |
| Any conditions affecting your blood (e.g. anaemia, sickle cell, blood cancers) |  |  |  |
| Liver, kidney or urinary tract disease? |  |  |  |
| Diseases of the digestive system? (e.g. crohn’s, coeliac) |  |  |  |
| Diabetes? |  |  |  |
| Autoimmune disorders / thyroid disease? |  |  |  |
| Conditions that could affect the skin? (e.g. eczema, psoriasis and cold sores or hayfever) |  |  |  |
| Bone or joint disease? (e.g., osteo or inflammatory arthritis, osteoporosis etc) |  |  |  |
| An infectious disease? (e.g. hepatitis B, hepatitis C or HIV, or CJD) |  |  |  |
| Any form of cancer? |  |  |  |
| Alzheimer’s disease or dementia? |  |  |  |
| Mental health diagnosis? (e.g. depression, schizophrenia, or bipolar disorder) |  |  |  |

**Have you ever had**  **Yes No Give details**

|  |  |  |  |
| --- | --- | --- | --- |
| Sensory, processing or behavioural challenges (e.g. autism, ADHD)? |  |  |  |
| A learning disability / cognitive brain impairment? |  |  |  |
| Hearing Impairments or experienced hearing loss? Or visual impairments or experienced sight loss? |  |  |  |
| Do you experience any mobility challenges or use mobility aids? |  |  |  |
| An operation under general anaesthetic in hospital? |  |  |  |
| Other treatment that required you to be in hospital? |  |  |  |
| Any other disabilities or conditions not listed above? |  |  |  |
| A DNR (Do Not Attempt Resuscitation) or Respect Form in place? |  |  |  |
| A Lasting Power of Attorney? (a legal document to appoint one or more persons to help you make decisions, or to make decisions on your behalf) |  |  |  |

|  |
| --- |
| **Please give any further information you think we should know about:** |
|  |

|  |
| --- |
| **Declaration and Signature:** |
| **I understand these questions and have answered them truthfully and to the best of my ability.**  **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **If not completed by the patient, please state relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Dental Registrant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GDC No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_** |