Braintree Dental Centre – New Patient Form

9c Coggeshall Road, Braintree, Essex, CM7 9DB
Tel: 01376 321061

To ensure we can provide you with the best possible service, please ensure all the information included within this document is accurate to the best of your knowledge. We will not share the information you provide with any third parties without your prior consent. It may be necessary to share this information with other care providers if referrals are required. A copy of our privacy notice can be found online or can be obtained within the practice upon request.

Basic Information

This information is about you personally. This will be used to ensure that all the data on our systems about you are up to date.

Title : Mr / Miss / Mrs / Ms / Dr / Other _____ Please Circle

Surname : _____

Forename(s) : _____

Date of Birth : ____/____/_____ DD/MM/YYYY

NHS Patient Number : _____

Address : _____

_____

_____

_____

Postcode : _____

Occupation : _____

Tel (Home) : _____

Tel (Mobile) : _____

Tel (Work) : _____

Email : _____

GP Name : _____

Doctors Surgery : _____

Emergency Contact : _____

Contact Number : _____

Medical History

Please ensure all the information provided below is accurate to the best of your knowledge. Providing us with incorrect medical details could put your life at risk and could also result in treatment plans that will not be best suited for your needs.

Question	Yes	No	Details:
Are you currently receiving any medical treatment? Not limited to the dentist/orthodontist			
Have you been a patient in hospital in the last two years?			
Have you taken any medicine / drugs in the last two years?			
Are you allergic to, or had any reactions to any medicines, anaesthetics, penicillin etc?			
Are you pregnant?			
Are you HIV positive?			
Are you at risk to HIV exposure?			
Are you receiving any steroids treatment?			
Are you taking medication for osteoporosis (Weak Bones)			

Please Check if you have any of the following

Rheumatic Fever		Epilepsy		Diabetes (Type 1)	
Diabetes (Type 2)		Anaemia		Asthma	
Severe Headaches		Hepatitis (Type A)		Hepatitis (Type B)	
Hepatitis (Type C)		Cold Sores		Bronchitis or Chest Problems	
Depressive Illness		Drug Dependence		Lung Trouble	
Other					

I confirm that I have made the clinician aware of all my normal drug usage, and that in the last three days I have not taken any of the following without informing the Clinician

Newly Prescribed Medications	Non-Prescribed Medications	Over-The-Counter Preparations
Recreational Drugs or Substances	Any other Substances	

Question	Yes	No
Do you Smoke?		
If you answered yes to the previous question, approximately how many cigarettes do you smoke over an average week?		
Do you have a high level of sugar intake? (Fizzy Drinks, Sweets, Sugar in Coffee/Tea Etc)		
Do you drink alcohol?		
If you answered yes to the previous question, approximately how many units of alcohol do you drink per week?		
Do you currently have any dental pain or problems?		
Have you ever had excessive bleeding / bruising from dental treatment?		
Do you become anxious or uncomfortable when having dental treatment?		

I understand that by failing to declare this information to the clinician may be detrimental to my treatment and/or my general health and wellbeing.

Medications

Please use this space to detail any medications you are currently taking or have taken within the last three days. Please ensure you provide accurate quantities and dosages. Providing us with incorrect information may affect your treatment and may affect your health

Name	Quantity	Dosage

General Data Protection Regulation (GDPR) Authorisation

Question	Yes	No
I give my consent for messages to be left on an answering machine and to speak to family members regarding appointment dates and/or times.		

Question	Yes	No
I would prefer to be contacted by Braintree Dental Centre regarding appointments via following methods. Please tick all that may apply. Please note that the practice uses texting and emails to remind you of your upcoming appointment. If you do not choose this method, you may not receive appointment reminders for upcoming appointments.		
Phone		
Text Message (SMS)		
Email		
Post		

Question	Yes	No
I authorise close family members to manage my appointments on my behalf.		

Question	Yes	No
The following questions relate to the use of your data for marketing purposes and your response will have no effect on your treatment or the care we provide to you as a patient at this practice.		
I permit the use of any of my personal data for the use of marketing, promotional, educational training or any other purpose than my care and treatment		
I do not permit the practice management to request using my personal data for any purpose other than my care and treatment		

Declaration

I certify that the information provided within this document is to the best of my knowledge and is a true and complete statement of my current medical state.

Signature	
Name	
Date	

If you a carer and are signing this document on behalf of the patient, please detail your relationship to the patient below. Without this we will be unable to add the information provided above to our system.

Relationship to Patient	