CAMBRIDGE ORTHODONTIC PRACTICE

Confidential Medical History Form

THIS FORM MUST BE COMPLETED ON BOTH SIDES BEFORE YOUR APPOINTMENT AND HANDED TO RECEPTION WHEN YOU ARRIVE.

PLEASE COMPLETE THIS FORM WITH THE DETAILS OF THE PATIENT WHO IS BOOKED IN TO SEE US. ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL BY THE PEOPLE CARING FOR YOU.

First Name:	Surname:	
Title:	Date of Birth:	Male / Female
Home Address:		
	Postcode:	
*NHS number:	E-mail:	
Tel: (Mobile)	Tel: (Daytime)	
In the event of emergency, please contact:		
Occupation:	Hobbies:	

*** YOUR NHS NUMBER IS REQUIRED FOR NHS TREATMENT / HOSPITAL REFERRALS: you can get this by calling your doctor, in a child's red health book or medical card * we are unable to begin NHS treatment without this information ***

Dentist Name:		Doctor Name:
Address:		Address:
Tel Nos:		Tel Nos:

Are you?	Yes	No	Please provide as much detail as possible if you ticked Yes'
Attending or receiving treatment from a doctor, hospital or clinic or specialist?			
Taking or have taken steroids in the last 2 years?			
Carrying a medical warning card?			
Are you taking any blood-thinning medication such as Warfarin, Aspirin, Clopidogrel, or Dibiratan?			
Taking Bisphosphonates or have you in the past 10 years e.g. Alendronic Acid/Risedronate/Etidronate			
Fitted with a Pacemaker?			

Do you suffer from?	Yes	No	Please provide as much detail as possible if you tick 'Yes'
Allergies to any medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods (e.g. nuts/shellfish)?			
Hay fever, sinus problems or eczema			
Bronchitis / Asthma? Do you use inhalers?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart conditions, angina, stroke? Heart surgery?			
Diabetes (or anyone in your family) Type 1 or Type 2?			
Blood Pressure? Taking any blood pressure medication?			
Arthritis or other bone/joint disease?			
Thyroid Problems (over or under active)			
Liver or Kidney Disease? Or had Jaundice?			
Any infectious diseases (e.g. HIV, Hepatitis, TB)?			
Any other serious illness?			

Clinician check: Signature.....Date.....

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Have you ever had?	Yes	No	Please provide as much detail as possible if you tick 'Yes'
Blood refused by the Blood Transfusion Service?			
Radiotherapy or Chemotherapy?			
A bad reaction to local or general anaesthetic?			
Cold sores?			
Brain Surgery?			
Growth hormone treatment before the mid 1980's			
A close relative with CJD?			

Alcohol Consumption:

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

Smoking/Tobacco:	Yes	No	In Past	Number a day	Years smoked?
Do you smoke any tobacco products now or in the past?					
Do you chew tobacco, paan, arecanut, supari, use gutkha (or did you in the past)? How many times a day?					

Females Only	Yes	No
Is there any possibility you may be pregnant?		
Have you had a baby in the last 12 months?		

General Information:	Yes	No	Please provide as much detail as possible
When was your last check up at your dentist? Please state month and year.			
Do you suffer with anxiety at the dentist? What can we do to make your visit more comfortable?			
Have you had previous orthodontic treatment?			
Have you ever had trauma to the teeth or chin?			
Have you ever had difficulty with extractions?			
Are you receiving any other dental treatment?			
Anything else you think we should know that would help our staff when treating you?			

Clinician check: Signature.....Date.....

Consent

1. I hereby authorise the Orthodontists (or designated staff) to take x-rays, impressions/study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis. These will be kept absolutely confidentially and securely and will only be used in my confidential clinical records.
2. Upon such diagnosis, I authorise the Orthodontist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. **If OVER 16 years of age** I hereby give consent to allow a family member, or representative (e.g. Carer or Personal Assistant (PA)), to book appointments, amend appointments or discuss any matters relating to myself, the patient. **Signature** .....

Communication Consent

4. I agree that the Cambridge Orthodontic Practice may use my email address/phone/mobile to contact me regarding appointments and related information to do with my treatment. I understand that I can withdraw my consent at any time by email to info@bracesrus.co.uk

I confirm that I have read and understood this form to the best of my knowledge ☐

FORM COMPLETED BY: Signature ..... Date: .....
Self ☐ Parent ☐ Guardian ☐

MEDICAL HISTORY UPDATE

Please check that the information on this form is still correct and list any changes below. This could include changes to your health, medication, telephone numbers, address details, dentist details and (where applicable) information on smoking and drinking.

DATE CHECKED	LIST ANY CHANGES BELOW OR STATE 'NO CHANGE'	SIGNATURE

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Communication Consent Form

We process personal data for the purposes of providing optimum healthcare, providing you with news about treatments and what is happening at the practice and informing you about our services and promotions. ***You can withdraw your consent*** *at any time by contacting us.*

The practice can contact me by: Email ☐ Phone ☐ Text (**Appointment reminders only**) ☐		
I would like to receive important practice announcements	Yes ☐	No ☐
I would like to receive details of practice services and promotions	Yes ☐	No ☐
I would like to receive information about brace care and any other aspect of my treatment	Yes ☐	No ☐
Other:	Yes ☐	No ☐

Your personal information will never be passed to third parties unless we are making a professional referral for you. If we have to consent for referral to another health care provider we will send them just the information that they need to provide the necessary assessment, tests or treatments.

For further details about how we process your personal information, please see our Privacy Notice at the reception waiting area, in the practice Information folder or contact us at *info@bracesrus.co.uk* to request an emailed copy of it.

Patient Name: _____ Patient Date of Birth: _____

Parent name (consent for under 16 year olds):_____

Signature: _____