Roseland Dental Practice

25 Fore Street, Tregony, Truro. TR2 5RN
Phone: 01872 530243 Fax: 01872 530737

We are required to hold the following confidential information about you, please complete or amend any inaccuracies. Please refer to the Privacy Notice on the Data Protection tab regarding how we store and use your personal data. A copy is also in the Practice Information folder or available from Reception.

FULL Name: ………………………………………………………… DOB: ………………………..

Home Address: ……………………………………………………………………………………

Telephone: Home: ……………………………….. Mobile: …………………… Work: ……………………..

Contact Email Address: …………………………………………………………………………

Best way to contact you: Telephone - Home ☐ Mobile ☐ Work ☐ Email ☐ Other (please state)

……………………………………………………………………………………………………

Do you have any special communication needs? Yes ☐ No ☐ If yes please state

Large Print ☐ Sign Language ☐ Other ☐ ………………………………………………….

Emergency Contact Details: Name: ………………………………… Phone No: …………………………

MEDICAL HISTORY

Your Doctor's Name & Surgery: ……………………………………………………………………...

1. Have you been in Hospital during the past few years? Yes ☐ No ☐
   Reason: ……………………………………………………………………………………………
2. Are you currently on any medication (tablets, capsules, drugs etc) from your Doctor? Yes ☐ No ☐
   List: ………………………………………………………………………………………………
3. Are you currently undergoing any medical treatment? Yes ☐ No ☐
   Details :…………………………………………………………………………………………
4. Are you allergic to anything? Yes ☐ No ☐
   Details: …………………………………………………………………………………………
5. Have you ever had any of the following? Yes ☐ No ☐
   - ☐ Rheumatic Fever
   - ☐ Anaemia
   - ☐ Asthma
   - ☐ Gastric Problems
   - ☐ Depressive Illness
   - ☐ Drug Dependence
   - ☐ Epilepsy
   - ☐ High Blood Pressure
   - ☐ Kidney Trouble
   - ☐ Cold Sores
   - ☐ Severe Headaches
   - ☐ Heart Trouble
   - ☐ Diabetes
   - ☐ Arthritis
   - ☐ Hepatitis – Specify type A, B, C
   - ☐ Bronchitis or Chest Problems
6. Have you had any prosthetic surgery? (eg heart valve or hip replacement) Yes ☐ No ☐
   Details: …………………………………………………………………………………………
7. Are you pregnant? If so, how many months: …………………………………….. Yes ☐ No ☐
8. Are you HIV positive or at risk to HIV exposure? Yes ☐ No ☐

DENTAL HISTORY

1. Name of previous Dentist: ……………………………………… Last Visit: ……………………………
2. Is there anything that might affect your ability to receive dental treatment? Yes ☐ No ☐
3. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? Yes ☐ No ☐
4. Do you have dental pain or a dental problem at present? Yes ☐ No ☐

If you have answered Yes to 2,3,or 4 please give details: ……………………………………..

Signed: ……………………………………………………………….. Date: ……………………………

Patient/Parent/Guardian/Advocate
RECORDS UPDATE

I have checked the records overleaf and confirm these to be correct or have noted any changes/ amendment below. I agree that I am being treated as a private patient/under the NHS.

Date	Tick if details correct	Details of changes/amendments	Signature