



Casual/Emergency and Direct Access Form

Personal Details: (Mr/Mrs/Miss/Ms/Other) Please state

Surname: First name:

Address:

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Postcode: Date of Birth:

Telephone Number: Mobile Number:

Email:

Occupation:

**I authorise Finedon Dental Practice to communicate with my next of Kin/
carer/ power of attorney* (please delete as appropriate)**

Their name:

Relationship:

Their contact number:

*If you have selected Power of Attorney, please complete a Mental Capacity form.

Permitted use of personal data

In the event that any person working at Finedon Dental Practice wishes to use any of my personal data for use for marketing, promotional, educational, training or any other purpose than my care & treatment, I permit the practice management to make an information request to me using the following method. Text Email Phone Letter

I DO NOT permit the practice management to request using my personal data for any purpose other than my care & treatment.

**Certain medical conditions can affect dental treatment and vice versa.
Please complete the medical history on the reverse of form.**

MEDICAL HISTORY

Yes No

COVID-19 TRIAGE. Do you currently have Covid 19?

If you smoke, what is your average per week?

What is your average weekly consumption of alcohol?

Please tick or tell the dentist if you are HIV positive

Have you ever had a joint replacement operation?

If yes, please give details

In the past 2 years have you been treated with hydro-cortisone or corticosteroids?

In the past 2 years have you undergone any operations?

If yes, please give details

Are you at present taking any medicine or tablets? *Please list below*.....

Are you allergic to any medicine, tablets, substances or latex? *Please list below*.....

Do you carry a medical warning card?

Do you have or have you ever suffered from any other serious illness?

If yes, please give details

Do you have or have you ever suffered from high blood pressure?

Do you have or have you ever suffered from excessive bleeding?

Do you have or have you ever suffered from hepatitis?

Do you have or have you ever suffered from chronic bronchitis or asthma?

Do you have or have you ever suffered from epilepsy or fainting attacks?

Do you have or have you ever suffered from diabetes?

Do you have or have you ever suffered from any heart complaint, heart surgery or stroke?

If yes, please give details

Are you pregnant?

Do you have or have you ever suffered from rheumatic fever?

Please include the name and address of your doctor

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING

PLEASE LIST ANY ALLERGIES

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Name.....**Signature**.....**Date**.....

Dentist Name.....**Signature**.....**Date**.....