Benfleet Dental Studio & Clinic - Digital Medical Declaration

Please fill in the entire form, digitally sign it and then send this to benfleetdental.clinic@nhs.net with the subject title: "**Medical History: Your Name**".

Please tick the service you are using: *

- ☐ NHS
- ☐ Private
- ☐ Work-place or Other Insurance (please specify in box to right)

Please specify which insurance you have:

Name *

Title First Name Last Name

Phone Number *

Area Code Phone Number

Address *

Street Address

Street Address Line 2

City

County

Postal Code

GP Details *

Name of GP Practice

Address

Postal Code

Have you had any Covid-19 symptoms in the past 2 weeks? This includes: High temperature, new & continuous cough, loss of change of smell or taste. *

- ◯ YES
- ◯ NO

If yes, please give details including when symptoms started/stopped:

Could you be pregnant?

- ◯ YES
- ◯ NO

Please tick whether you have any of the following:
If you need to write more details, please use the box below each condition.

Bronchitis, asthma or other chest conditions? *
- ◯ YES
- ◯ NO

Fainting attacks, giddiness, blackouts, epilepsy? *
- ◯ YES
- ◯ NO

Heart problems, angina, blood pressure, stroke? *
- ◯ YES
- ◯ NO

Details:

Diabetes? Or... does anyone if you family have diabetes? *
- ◯ YES
- ◯ NO

Bone or joint disease? (e.g. arthritis) *
- ◯ YES
- ◯ NO

Bruising or persistent bleeding after injury? *
- ◯ YES
- ◯ NO

Details:

Liver disease (e.g. hepatitis) or Kidney disease? *
- ◯ YES
- ◯ NO

Any other serious illness or infectious disease? *
- ◯ YES
- ◯ NO

Heart surgery or stent? *
- ◯ YES
- ◯ NO

Details:

Blood refused by blood transfusion service? *
- ◯ YES
- ◯ NO

A bad reaction to general or local anaesthetic? *
- ◯ YES
- ◯ NO

Any form of mental health problem? (e.g. anxiety) *
- ◯ YES
- ◯ NO

Details:

Please list any prescribed medicines, or over-the-counter supplements, you take on a routine basis? *

Do you have any allergies? Please list all allergies and the reaction you had e.g. swelling/rashes. *

Social History

Please answer this honestly as it helps us to tailor our preventive regimes and advice.

What is your profession? *

Do you smoke or chew any tobacco products? *

- ☐ Yes
- ☐ No
- ☐ In the past

If yes or in the past: How many times per day?

Do you vape or use e-cigarettes? *

- ☐ Yes
- ☐ No
- ☐ In the past

What % of Nicotine is the vape/e-cig?

How many times per day?

DECLARATION

By digitally signing this medical form, I am confirming that the information in this form is accurate and up-to-date. I will not hold the dental practice accountable or liable for anything arising from undisclosed information.

Today's Date

Month Day Year

Signature (Full name in CAPITALS:) *