NHS Payment Exemptions

☐	Under 18 years of age
☐	Age 18 years and in full-time education
☐	Pregnant mother
☐	Mother with baby under 12 months
☐	Holder/partner of person on current HC2 certificate
☐	Holder/partner of person on current HC3 certificate
☐	Income support
☐	Income-based Jobseeker's Allowance
☐	Income-related Employment & Support Allowance
☐	Pension Credit Guarantee
☐	NHS Tax Credit Exemption Certificate

Completed by (✓) ☐ Self ☐ Parent ☐ Guardian

Signature: _____ **Date:** ____ /____ /____

Confidential Medical History Form

All information will be kept strictly confidential by the people caring for you.

Personal Details

Title:	First Name:	
	Surname:	
	Date of Birth: ____ /____ /____	Male / Female

Address:
Postcode:
Home Telephone:
Mobile:

Email:
NHS Number:
Occupation:

GP/Doctor's Details

Doctor's Name:
Address:
Postcode:
Telephone:

How did you find us? (✓)

☐ Location ☐ Family / Friend ☐ Recommended ☐ Online ☐ Other

Are you currently	Yes / No	Give Details
Receiving treatment from a doctor, hospital or clinic?	☐ ☐	
Taking any prescribed medicines (eg tablets, ointments, injections, inhalers, contraceptive pill, hormone replacement therapy)?	☐ ☐	
Carrying a medical warning card?	☐ ☐	
Pregnant or possibly pregnant?	☐ ☐	

Have you ever suffered from	Yes / No	Give Details
Allergy to medicines (eg penicillin), substances (latex/rubber) or foods?	☐ ☐	
Bronchitis, asthma or other chest condition?	☐ ☐	
Fainting attacks, giddiness, blackouts, epilepsy?	☐ ☐	
Blood pressure, heart problems, angina, stroke?	☐ ☐	
Diabetes?	☐ ☐	
Bone or joint disease?	☐ ☐	
Bruising, persistent bleeding following injury, tooth extraction or surgery?	☐ ☐	
Liver disease (eg jaundice, hepatitis) or kidney disease?	☐ ☐	
Any other serious illness or infection disease (eg HIV)?	☐ ☐	
Blood refused by the Blood Transfusion Service?	☐ ☐	
A bad reaction to general or local anaesthetic?	☐ ☐	
Treatment that required you to be in hospital?	☐ ☐	
Heart surgery?	☐ ☐	

Alcohol

How many units of alcohol do you drink per week?	_____ Units per week

Smoking	Yes / No / In the past
Do you smoke any tobacco products now?	☐ ☐ ☐ _____ times per day
Do you chew tobacco, pan?	☐ ☐ ☐ _____ times per day

Please give any other details which your dentist might need to know about, such as self-prescribed medicines (eg Aspirin) or any disabilities you may have.

Are you interested in	Yes / No
Teeth Whitening?	☐ ☐
Straight Teeth?	☐ ☐
Cosmetic Veneers / Hollywood smile?	☐ ☐
Facial anti-wrinkle injections?	☐ ☐