Electronic communications – patient notice and consent

Notice to patients

Emails and text messages are now an integral part of everyday life for many people and can improve and simplify the way we communicate with our patients. However, we will only send you emails or texts if you give us your permission to do so.

Emails and text messages are not always secure so we will not include personal information about your health, unless you ask us (in writing) to do so.

We will not pass on your contact details, including your email address or telephone number, to any third party.

If you are willing for us to communicate with you by email and/or text to remind you of booked appointments, amounts due and/or information about our services, please complete this form and return it to **Hannah Morrissey, Practice Manager.**

Patient agreement

I agree that **University Dental Care** may send me reminders and information about:

☐ Appointments (routine check-up reminders and booked appointments)

☐ Outstanding Payments

☐ Services provided by the practice

I prefer these communications to be sent by

☐ Email – please provide email address ________________________________

☐ Text – please provide mobile number ________________________________

I understand that I can opt out from receiving these communications at any time by speaking to a receptionist or to my dentist and asking them to amend my records.

Patient name: ____

Patient signature: ______________________________ Date: ______________

Medical History - Confidential Patient Questionnaire

Title: Surname:	First Name:
Date of Birth: / /	Occupation:
Address:	Tel: Mobile: Email:
Your Doctor's name and address:	Next of Kin:

Are you:	Yes	No	Details
Attending or receiving treatment from a Doctor, Hospital or Clinic?			
Taking any Medicines/Tablets/Injections?			
Taking or have you taken steroids in the last two years?			
Allergic to anything (e.g. Antibiotics/Latex)?			
An expectant mother?			

Have you:	Yes	No	Details
Any heart problems, Pacemaker, Heart Murmur, Angina, Blood Pressure?			
Had Rheumatic Fever, Chorea (St. Vitus Dance)?			
Had Jaundice, Liver, Kidney Disease, HIV or Hepatitis?			
Had a bad reaction to Local or General Anaesthesia?			
Had Brain Surgery?			
You or a close member of your family ever suffered from CJD?			

Do you:	Yes	No	Details
Suffer from Asthma, Diabetes or Epilepsy?			
Have Arthritis?			
Bruise easily or have Prolonged Bleeding?			
Get Cold Sores? (If you have an active Cold Sore we are unable to treat you).			
Do you **smoke**? If Yes please state number per day.			
Do you **drink alcohol**? If yes and it is more than 7 pints of beer or 14 measures of spirit or 14 glasses of wine **per week -** state amount.			
Are there any other aspects concerning your health that you think the dentist should know about?			

Signature: ……………………………………………………. Date: …………………………………………………

GDP Signature: ………………………………………………

Updated Signature	**Updated Date**

A Welsh version of this form is available on request.

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