Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(location if known of Dental Rescue Day)

First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_ /\_\_\_\_ /\_\_\_\_

Telephone: Home: \_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_

Referring Charity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_

Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all drugs / medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all allergies you suffer from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any of the following? (Tick Y or N for every question.)

Y N Y N

Rheumatic fever 🞏 🞏 Diabetes 🞏 🞏

Radiation therapy 🞏 🞏 Epilepsy (fits) 🞏 🞏

Women: Pregnant? 🞏 🞏 Asthma 🞏 🞏

High/low blood pressure 🞏 🞏 Osteoporosis 🞏 🞏

Heart problems 🞏 🞏 Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Joint surgery 🞏 🞏 Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Infectious diseases 🞏 🞏 Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding problems 🞏 🞏 Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIV / Aids / Hepatitis 🞏 🞏 Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your dental problems? (Tick Y or N for every question.)

Y N Y N

Toothache 🞏 🞏 Appearance 🞏 🞏

Swelling / infection 🞏 🞏 Other 🞏 🞏

Broken teeth 🞏 🞏

Sensitive teeth 🞏 🞏 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding gums 🞏 🞏

I agree to be treated on a National Dental Foundation (NDF) day at no fee. I realise that some dental work may not be treated or diagnosed on this day and that I may require further appointments elsewhere in the future. I hold harmless the NDF for any treatment provided. I authorise the release of my dental records including any x-rays or photographs that may be taken for publication or research relative to the NDF programme.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_ /\_\_\_\_ /\_\_\_\_