

LANCASTER HOUSE DENTAL PRACTICE

CONFIDENTIAL PATIENT QUESTIONNAIRE

This provides the dentist with important information required for your Dental treatment and Oral Health Care. Please complete this form as accurately as possible. All information is treated as private and confidential.

Surname (Mr/ Mrs/ Miss/ Ms/ Dr)	
Forenames:	
Date of birth:	
Home address:	Work address:
Postcode:	Postcode:
Tel. No. Home:	Work:
Mobile:	Email address:
Occupation:	
Name of your Doctor:	
Address:	
Name of your previous Dentist:	
Address:	
How did you hear about Lancaster House Dental Practice? <i>(Please tick)</i> Sign outside <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Thomson Local <input type="checkbox"/> A friend/ acquaintance <input type="checkbox"/> Please name:..... A member of the family <input type="checkbox"/> Please name:..... Other means <input type="checkbox"/> Please give details:.....	
Would you like to receive your dental care under private contract? Fully <input type="checkbox"/> Partly <input type="checkbox"/> None <input type="checkbox"/> Under NHS? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Would you like to be informed of superior quality materials or treatments not available/ allowed on the NHS? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please inform your dentist) <i>Please note that treatment for cosmetic/social reasons is not available on the NHS</i>	
If there was anything about your teeth or smile that you could change what would it be? Eg. Discoloured teeth, gapped, crooked, cracked or worn down, missing teeth, etc	
Are you confident about your smile? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you show your teeth when you have your picture taken? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you have loose or ill-fitting dentures? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you become anxious or uncomfortable when you are having dental treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Are you exempt from NHS dental charges? Eg. If claiming: Income support, JSA, Working family tax credit, Pension Credit, HC2 certificate, pregnant or nursing mother, etc

Yes No If yes give details:.....

Evidence of entitlement to free NHS dental treatment is required.

Practice policy:

Failed appointments:

When you book an appointment that time is reserved for you. We therefore would not offer that appointment time to other patients who may also wish to be seen. You can help us to keep waiting times to a minimum and keep our fees competitive by giving as much notice as possible if you cannot attend. We can then offer that time to patients who may be in pain and require urgent treatment. You will appreciate that when an appointment is not kept the practice still incurs overheads during that unproductive time. Therefore we have a strict policy of charging for missed appointments or where a full working days notice is not given for cancellations. The charge depends on the time allocated.
Repeated failed appointments will result in future treatment being declined.

Paying for your dental care

For NHS treatment payment is required at the start of your treatment. Where private treatment is being undertaken we may be able to arrange payment in stages.

Failure to make payment within 28 days of the payment date will result in administration fees (£10) being added to your account and the matter being referred to our Debt Collection Agents whose charges will be added to the outstanding amount (currently 35% plus VAT).

Patients will only be registered at this practice if agreeing to the policies stated above. Please confirm your acceptance by signing below:

Signed:

Date:

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Lifestyle and Medical History			
Please give details about any smoking or drinking habits:			
Do you smoke? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how many a day?.....			
Do you drink alcohol? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how many units a week?			
Do you chew betel/ areca nut/ "paan" or tobacco? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Give details:			
Are you currently receiving any dental treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Give details:			
Are you an expectant mother? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, expected date of delivery			
	<u>Yes</u>	<u>No</u>	<u>Details</u>
Are you taking any medication prescribed by your doctor, hospital or clinic?			
Are you taking any "over-the-counter" medicines or supplements?			
Have you taken any medicine tablets, capsules or drugs during the past two years?			
Have you been hospitalised? If 'yes' for what and when?			
Have you been diagnosed with HIV?			
Have you suffered from Rheumatic fever (St. Vitus Dance)?			
Are you allergic to any drugs? Eg. penicillin			
Do you have any other allergies? eg rubber/ latex, nickel, elastoplast?			
Have you suffered any heart complaints?			
High blood pressure?			
Any chest complaints? Eg. Breathlessness, asthma			
Have you suffered from: Epilepsy?			
Diabetes?			
Jaundice, Hepatitis, Kidney / Liver disease?			

	Yes	No	Details
Arthritis?			
Headaches, dizziness, fainting?			
Excessive bleeding?			
A bad reaction to general/ local anaesthetic?			
Have you ever had your blood refused by the Blood Transfusion Service?			
Have you ever suffered with a depressive illness?			
Please give details of any other information that the dentist should know:			
Completed by Self/ Parent/ Guardian?			
Signature Date			

Medical history updated:	Signature	Date
Medical history updated:	Signature	Date
Medical history updated:	Signature	Date
Medical history updated:	Signature	Date