LANCASTER HOUSE DENTAL PRACTICE

NEW PATIENT *CONFIDENTIAL MEDICAL & SOCIAL HISTORY 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/Mst/ Mrs/ Miss/ Ms/ Dr)	
Forenames:	
Date of birth:	Occupation:
Home address: ……...…… ……..... ……..... ……..... Postcode:	Work address: …….……..…… ……..... ..... …… Postcode:
Tel. No. Home:	Work:
Mobile:	
Home Email address:	Work Email address:

Details of person to contact in an emergency:

Name: …….. Phone Number:……

Name of your Doctor: ……..
Address:

Name of your previous Dentist: ……..…..
Address:

How did you hear about Lancaster House Dental Practice? *(Please tick)*
Sign outside Yellow Pages Yell.com Thomson Local Internet search
Details:…….
A friend/ acquaintance/referred by dentist or doctor Please name:…….
A member of the family Please name:……..……
Other means Please give details:…….....

Would you like to receive Private Dental Care?
Yes (fully private) *Mixture(Private & NHS)* *No (NHS only)*
Please note that treatment for cosmetic/social reasons is not available on the NHS eg. Stain removal

Would you like to be informed of superior quality materials or treatments not available the NHS? *Yes* *No*

Are you exempt from NHS dental charges? Eg. If claiming: Income support, JSA, Working family tax credit, Pension Credit Guarantee 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:

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 for any appointment. We can then offer that time to patients who may be in pain and require urgent treatment. Therefore we have a strict policy of charging for missed appointments or where a minimum of a full working days' notice is not given for cancellations. The charge depends on the time allocated. Longer notice periods are required for appointments booked for more than half an hour. Repeated failed appointments will result in future treatment being declined.

Paying for your dental care

Payment for NHS treatment is required at the start of your treatment. Where private treatment is being undertaken we may be able to arrange payment in stages. The practice reserves the right to take a deposit before booking long appointments or for certain types of treatment.

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 seen at this practice if in agreement to the policies stated above. Please confirm your acceptance by signing below:

Signed: **Date:**

DENTAL HISTORY:

Do you become anxious or uncomfortable when you are having dental treatment? *Yes* *No*

How often do you *(please circle)* **brush** your teeth? *daily/twice daily/occasionally*
floss? *daily/ occasionally/ never*
use interdental brushes (eg. Tepe) *daily/ occasionally/ never*

When did you last attend a dentist? ☐*<6 months* ☐*6-12 months* ☐*1-2years* ☐*>2years*
How would you describe your attendance? ☐*Attend regularly*
☐*Attend for Urgent Care Only*

SOCIAL HISTORY:

Do you have a high sugar diet? ☐*Yes* ☐*No*
Do you have a diet high in acidic/fizzy drinks? ☐*Yes* ☐*No*

Do you suffer with reflux or an eating disorder? ☐*Yes* ☐*No*

Do have poorly controlled diabetes? ☐*Not applicable* ☐*Yes* ☐*No*

Do you smoke? ☐*Yes* ☐*No.* *If yes, what do smoke? Eg. Cigarettes, cigars, pipe, roll-ups*
_____
If yes, how many per day? ☐*<5* ☐*5-10 per day* ☐*11-20 per day* ☐*>20 per day*
If No, have you smoked in the last 5 years? ☐*Yes* ☐*No*

Do you chew tobacco or paan? ☐*Yes* ☐*No*

Do you drink alcohol? ☐*Yes* ☐*No*
If yes, how many units a week? ☐*<7* ☐*8-14 units* ☐*15-21 units* ☐*>21 units*
A unit is half a pint of lager, a single measure of spirits or a small glass of wine/aperitif.)

With regards to your teeth and mouth, what is the main purpose of your visit today?

☐1. Infection
☐2. Pain
☐3. Concerns about appearance
☐4. Concerns about dental health
☐5. Concerns about function
☐6. Denture problem
☐7. Restoration problems (eg. Fillings/ crowns/ bridge etc.)
☐8. Other: ……..
☐9. No problems at present

What is your ethnic group? Please choose **ONE** selection from the list below to indicate your ethnic group:

☐ Patient Declined
☐White British
☐White Irish
☐Other White Background
☐White and Black Caribbean
☐White and Black African
☐White and Asian
☐Other Mixed Background
☐Asian or Asian British Indian
☐Asian or Asian British Pakistani
☐Asian or Asian British Bangladeshi
☐Other Asian Background
☐Black or British Caribbean
☐Black or British African
☐Other Black Background
☐Chinese
☐Any Other Ethnic Group

MEDICAL HISTORY

Are you an expectant mother? Yes No
If yes, expected date of delivery …….

	Yes	No	Give Details
Are you taking any medication prescribed by your doctor, hospital or clinic? *(eg. Tablets, ointments, injections or inhalers, including contraceptives or hormone replacement therapy)*			
Are you taking any "over-the-counter" medicines or supplements?			
Are you carrying a medical warning card?			
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?			
Are you at risk of HIV exposure?			
Have you ever suffered from:			
Allergies to medicines (eg. Penicillin), substances (eg. latex/rubber/nickel/Elastoplast) or foods?			
Bronchitis, asthma or other chest conditions?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart problems, angina, blood pressure problems, or stroke?			
Heart surgery?			
Diabetes (or does anyone in your family)?			
Bone or joint disease? Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Liver disease (eg. Jaundice, hepatitis) or kidney disease?			
Any other serious illness or infectious disease?			
Blood refused by the Blood Transfusion Service?			
A bad reaction to general or local anaesthetic?			
Depressive illness?			
Drug dependence?			
Is there any other information which your dentist should know? *Eg. Diagnosed as special needs, Disabilities, any other information*			

Completed by *(please tick)* *self* *parent* *guardian*

Patient's signature …… Date ……

Dentist's signature …… Date ……

MEDICAL HISTORY UPDATE			
Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below			
Date	**No change**	**List any changes below**	**Patient's initials**