enhance
dental • cosmetic • training

CONFIDENTIAL PATIENT QUESTIONNAIRE

Personal Details

First Name:_____ Surname:_____ Dr / Mr / Mrs / Miss / Ms

Home Address: _____ Work Phone: _____

_____ Date Of Birth: _____

Post code _____ Email Address: _____

Home Phone: _____ NHS Number: _____

Mobile No: _____ NHS Exempt: **Yes / No**

Occupation: _____ Details of Exemption: _____

MEDICAL HISTORY

GP Surgery Name: _____ Phone (If known): _____

1. Are you receiving any medical treatment? Yes / No Details: _____
2. Have you been hospitalized during the past two years? Yes / No Details: _____
3. Have you taken any medicines during the past two years? Yes / No Details: _____
4. Are you allergic to anything including medicines etc? Yes / No Details: _____
7. Have you had any prosthetic surgery? Yes / No Details: _____
8. Woman, Are you pregnant? If so, how many months: _____
9. Do you smoke? Yes / No. If yes how many cigarettes a day? _____
10. How many units of alcohol do you drink per week? _____
11. Have you ever had any of the following? If so, please tick as appropriate.

Rheumatic Fever	☐	Epilepsy	☐	Cold Sores	☐
Heart Trouble	☐	Anaemia	☐	Mental Health Conditions	☐
High Blood Pressure	☐	Diabetes	☐	Drug Dependence	☐
Asthma	☐	Kidney Trouble	☐	Hepatitis -Specify type A, B,C	☐
Arthritis	☐	Gastric Problems	☐	Bronchitis or Chest Problems	☐

DENTAL HISTORY

1. Name of Last Dentist: _____ 2. Approximate date of last dental visit: _____
3. Do you have Dental pain or a Dental problem at present? Yes / No Details: _____
4. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts? Yes / No
5. Do you become anxious or uncomfortable when you are having dental treatment? Yes / No

Referred By:

Google ☐ Facebook ☐ Street Sign ☐ Another patient/friend (Name)_____

I hereby consent to the dental surgeon to carry out dental treatment, identified, discussed and agreed. I agree to be liable for any charges that may arise following treatment (this includes any debt collection surcharges).Payments are taken at each visit.

Signed: Patient/Parent/Guardian _____ Date:_____

Updated date_____ **Signed**_____ **Updated date**_____ **Signed**_____

Data Protection

The data protection act and GDPR prevents any person or organisation from accessing or sharing personal information on an individual without their express permission. Should you wish for another individual to be able to make/amend/discuss your dental appointments/information on your behalf, please confirm below:

Yes ☐ No ☐ Name: _____ Relationship: _____ Phone Number: _____

Details of person to contact in an emergency

Name: _____ Relationship: _____ Phone Number: _____

I authorise Enhance Dental Centre to contact me in the following methods regarding my personal dental information/appointments.

Home Phone ☐ Mobile ☐ Work Phone ☐ Email ☐ Letter ☐

Signed: Patient/Parent/Guardian:_____**Date:**_____