BDS

-Ballybot Dental Surgery Ltd-

Company Registration Number NI064635

WELCOME TO BALLYBOT DENTAL SURGERY

In order to ensure that all your needs and wishes are met over the course of your treatment we require you to complete the questions asked below. Your answers will help the dentist to formulate a treatment plan to suit you and enable them to discuss any queries or concerns you may have in person.

We thank you for choosing Ballybot Dental Surgery and we will endeavour to provide you with the standard of care we are renowned for.

Your Name _____ DOB: _____

How did you hear about Ballybot Dental Surgery? _____

Have you viewed our website? YES/NO Any comments? _____

What are your current concerns about your teeth? _____

_____

What problems are these causing you? _____

_____

What would your ideal outcome be? _____

_____

Have you a timescale in mind or a deadline to meet? _____

_____

Are you nervous about having dental treatment carried out? _____

_____

What would you like people to say about your teeth?_____

_____

What is your occupation? _____

Would a better smile be of benefit to you in your line of work? _____

_____

Any other comments _____

_____

We thank you for taking the time to tell us how you feel about your teeth at present and we are looking forward to meeting your goals.

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CONSENT FORM RELATING TO YOUR DENTAL RECORDS, X-RAYS AND PHOTOGRAPHS

In line with best clinical practice, we seek your consent to use and disclose your dental information (consisting of your dental records, X-rays and photographs) in order to:

1. Carry out treatment, either within the surgery or by referral to another outside facility;
2. Arrange for laboratory work to be prepared for you;
3. Manage/facilitate the reimbursement of payments (e.g. by insurance claim forms, Dept. of Revenue MED2 form claims or electronically to the Business Services Organisation of the National Health Service); and
4. Assist in the pursuance of dental continuing professional education and/or practice promotion: for these purposes we will ensure that all X-rays and photographs will be made anonymous and no identifying features will be visible.

You have the right to revoke this consent at any time by providing this revocation in writing and addressing it to your dentist. Please note that in revoking this consent, this will not affect any action undertaken whilst consent was in place.

All of the above actions will be undertaken in accordance with the framework of the Data Protection Act UK 1988, which is overseen by the Information Commissioner's Office (see www.ico.gov.uk for further guidance). This is in order to ensure patient confidentiality at all times.

For persons under 18 years of age, it is necessary for a parent/guardian to sign this consent form.

CONSENT

I, the undersigned, give my consent for my records to be used in the lawful execution of the practice of dentistry and the provision of my dental care in line with the explanation above:

Name of signatory _____ Date: _____

If you are signing on behalf of someone under the age of 18, please state their name and DOB below along with their relationship to you:

Name of child: _____ DOB: _____

Relationship to above named: Parent/Guardian/Other
(delete as appropriate)

If Other, please specify _____

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CONFIDENTIAL PATIENT QUESTIONNAIRE

Name: _____

First Name(s) Surname Dr / Mr / Mrs / Miss / Ms

Date of Birth _____

Home Address including postcode: _____

_____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____

Details of person to contact in an emergency:

Name: _____ Phone Number: _____

Medical Doctors Name: _____ Phone (If known): _____

MEDICAL HISTORY

1. Are you receiving any medical treatment at the present time? Yes / No
   Details: _____
2. Have you been a patient in hospital during the past two years? Yes / No
   Reason: _____
3. Have you taken any medicine tablets, capsules or drugs during the past two years? Yes / No
   Details: _____
   Are you currently taking any BISPHOSPHONATE medications? YES/NO Details _____
4. Have you experienced any allergies or unusual effects from any tablets,drugs,injections or anaesthetic? Yes / No
   Details: _____
5. Are you, or have you been, under the care of a doctor during the past two years? Yes / No
   Reason: _____
6. Have you ever had any of the following? If so, please tick as appropriate.

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

7. Have you had any prosthetic surgery? (eg Heart Valve or Hip Replacement) Yes / No
   Details: _____
8. ***Ladies of reproductive age only:*** Are you pregnant? Yes / No **If yes,** your due date: _____
9. Are you at risk to HIV exposure? Yes / No
10. In the past 2 years have you been treated with hydrocortisone or corticosteroids? Yes / No
11. Do you smoke Yes / No 12. What is your average weekly consumption of alcohol? _____units
    (1 unit = 1 glass of wine, 1 spirit or ½ pint of beer)

Signed: Patient/Parent/Guardian _____ Date: _____