Cambridge Dental Hub

Patient registration forms

Title (i.e Mr, Mrs, Miss, Dr)			
Forename		Surname	
Gender		Date of Birth	
Address			
City/ Town		Postcode	
Home telephone		Work telephone	
Mobile (1)		Mobile (2)	
Home email			
Work email			
Occupation			
Introduced by		Insurance details	
Name of current/ previous dentist			
Name of current GP			
Name and address of GP practice			
Legal guardian (i.e. parent of child, carer)	Name:	Relationship to patient:	Mobile: Email:
Next of Kin/ I. C.E (in case of emergency)	This person will be authorised to speak on your behalf:		Phone number:

Legal basis for our practice processing data:
"9(2)(h) processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services on the basis of Union or Member State law or pursuant to contract with a health professional"

By signing this form it means that you are consenting to allow us to process your data, keep your personal data secure, accurate and readily available if you want to gain access to it. We follow the latest GDC, CQC and ICO rules and regulations on Data Protection and Information Governance.

Ticking the box allows us to communicate with you about matters pertaining to dental health, dental appointments, and dental treatment at our practice until further notice. If you no longer wish to receive letters, phone calls, text messages or emails then contact us and we will delete your contact information ☐

For further information and/or to see/have a copy of our privacy policy please ask reception or visit our website www.thehubdentalpractice.co.uk

For the protection of our patients and staff we use CCTV monitoring at the practice: in the reception area, corridors and treatment areas. By signing this form it means that you are consenting to their use. For further information please ask at the reception or visit our website at www.thehubdentalpractice.co.uk

By signing this form it means I realise that I am being treated as a private patient and understand this is a completely private dental practice and I undertake to pay the necessary fees.

Patient Name:________________________________

Date of birth____/_____/_______

Patient Signature :___________________

Date of Signature____/_____/________

www.cambridgedentalhub.co.uk

a. 1 Brooke house, Kingsley walk, Newmarket Road, Cambridge, CB5 8TJ
t. 01223 363277 **m.** 07973227415

Cambridge Dental Hub

Informed consent for emergency treatment

- We are a completely private dental practice offering emergency dental appointments and treatment, as well as general dental appointments and hygienist appointments. **It is important to note that we do not offer any NHS treatment ourselves**, though we do sometimes refer patients to NHS hospitals or practices for further treatment or appointments.

- We always provide a personalised written treatment plan to patients, which include treatment costs, along with consent forms which contain important information about treatment risks. This is a very important part of informed consent. **It is very important that patients read all these forms, and feel free to ask the dentist any questions that you may have. You should only sign forms if you are completely happy and agree.** We are here to help and we are more than happy to explain things further to you.

- **We always offer a free follow up review after any dental treatment within 4 weeks**, though we cannot always guarantee you will be seen by the same dentist who saw you first. This means that if you still experiencing pain or discomfort after treatment you can see a dentist who will discuss further options and if any additional treatment may be needed. (additional charges may apply). **Full check ups are £25**, plus the cost of any additional x rays.

- Patients will never be expected to make a decision on the day . Whilst we are more than happy to offer treatment straight away if possible; we encourage patients to take time to think about the options and book at a later date or later in the day. **There is no pressure to decide or agree to have treatment.**

- Because of the nature of dental treatment, especially emergency dental treatment, **we encourage patients to have somebody to take them home afterwards**. It is important that patients let us know if they feel they need somebody to pick them up or order a taxi and we are more than happy to help them arrange this.

- **It is practice policy to take full payment prior to treatment for new patients.**

- We normally answer the phone 24 hours a day but in the rare event this does not happy and you feel that you have a problem or complication that cannot wait, then **you can call 111 or if in any doubt, go straight to casualty.**

- In the emergency appointment, the dentist will focus on the presenting problem (ie your pain) and usually a full check up is done at a later date. X-rays are almost always needed and the dentist will explain this to you. A review can be done which is free for up to 4 weeks after the original appointment), though additional x rays may be needed and charges apply. **A full check up is £25.**

- If you have seen a dentist recently and have copies of any x-rays taken, please inform reception upon arrival. They must be of excellent quality, clearly show your name and the date they were taken.

- **Our charges:**
  - **Emergency examination- £25 (the same fee as a normal patient examination)**
  - **Full Check up- £25**
  - **Large x-ray- £35**
  - **Small x rays £9 each**

- **Signing this form means you are agreeing/ acknowledge that:**
  - **The fees for the emergency examination and x-rays have been explained to me to my complete satisfaction**
  - **You realise that there is a minimum charge today of £25 even if no treatment is provided**
  - **That you are freely giving your informed consent to allow one of our dentists to examine you**
  - **That you have read and understood the full contents of this consent form**
  - **That you have been given the opportunity to ask questions**
  - **You are under no obligation to have any treatment today or in the future, nor pay for any treatment that you have not received.**

Patient Name:___________________________________ Patient Signature :__________________

Date of birth____/_____/_______ Date of Signature____/_____/________

Medical History Part I

If you need more space, please use the extra space in the next page or ask reception for additional paper.

Medical Questions	Yes/No	If yes please give details below.
Are you a smoker? (This can seriously affect the success of dental treatment and dental health). If Yes how many a day?		
Are you attending or receiving treatment from a doctor, hospital, clinic, or specialist?		
Are you taking any medications? (Tablets, creams, ointments, injections, inhalers or others)? (if you need more space, please use the section at the end or ask reception for more paper)		
Are you pregnant if yes give projected birth date?		
Are you taking or have you taken steroids (in any form) in the last five years?		
Have you ever had cancer or are you taking or have you ever taken Bisphosphonates or any other drug related to cancer treatment?		
Are you allergic to any medicines, food, materials or suffer from hay fever, eczema or other allergies?		
Have you had rheumatic fever or chorea (St Vitus dance) or history of Infective Endocarditis?		
Have you had any history of any kind of Hepatitis, had jaundice, Liver disease, Kidney disease, Thyroid disease, had a joint replacement or carry a warning card (Heart, kidney, joint)?		
Have you had any blood tests, inoculations, etc in the last 2 years?		
Have you or any of your family been treated with growth hormone or resided with any one with NV CJD or TB?		
Have you ever had your blood refused by the blood transfusion service and if yes what was the reason?		
Have you been hospitalised in the last 12 months? Or been treated as a day case? If "yes" what for & when?		
Have you ever been treated for depression, anxiety, sleeping disorder, panic attacks or had a nervous breakdown?		
Have you ever been registered disabled or had disability allowance?		
Do you suffer from ulcers, rashes, itchy skin anywhere on your body or ever get cold sores		
Have you ever had a bad reaction to a general Anaesthetic or sedation or had a bad reaction to an injection or any other adverse reaction while having dental treatment?		
Do you have arthritis or any other problems with your joints or have you ever been treated for Osteoporosis? If yes give details of any treatment/medication in the last 5 years.		
Have you ever been told you have a heart murmur, other heart problem, angina, high or low blood pressure, have had a heart attack, have a pacemaker, or have you had any form of heart or blood vessel surgery?		
Do you suffer from bronchitis, difficult breathing, snoring or other chest condition or suffer from any breathing or sleeping disorder (COPD or Sleep Apnea)		
Do you suffer from asthma? If yes give details of any asthma medication you have taken in the last 5 years; and if yes give details of the last attack and how many attacks in the last 12 months; and if yes give details of any subsequent hospital admission or visit to casualty		

Date of birth____/_____/_______

Patient Signature :___________________

Patient Name:_____________________________________

Date of Signature____/_____/________

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Medical History Part II and Dental Health History

Medical Questions	Yes/No	If yes please give details below.
Do you experience fainting attacks, giddiness, blackouts or epilepsy?		
Are you Diabetic? If yes what type of Diabetes and list your medication?		
Have you ever had a bleeding disorder, taken Warfarin or any other anticlotting agent, or do you bruise easily or bled excessively following a tooth extraction, surgery or injury?		
Do you consume alcohol, and if yes then indicate units per week?		
Have ever been a registered drug addict or treated for substance abuse? Or do you use or have used in previous 6 months, any illegal substances (Pot, Heroin, methadone etc)		
Are there any other aspects concerning your health that you think the dentist should know about? Medical histories help to identify problems that affect your dental health and the effectiveness of your dental care. If you answered yes to any questions e.g. any illness, medication or medical problem please give details below.		

Please give the name of your previous or current dentist	
Please give the date of your last dental appointment?	
What was the date of your last hygienist appointment?	
Would you like to have a full check up or only focus on the emergency today?	
Do your gums bleed easily?	
Have you previously been diagnosed with gum disease?	
Have you ever had dental treatment with a specialist?	
Are you nervous or apprehensive about dental treatment?	

Please describe your **Current Dental Problem** (describe the signs and symptoms, how long it has been going on, what attempt. have been made to sort out the problem by yourself, your doctor or dentist) Examples include: Tooth pain top for last 3 days, taking pain killers.

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Please describe your **Your Expectations** (describe what would be a favourable outcome to your presenting problem. Examples include: Extracting my tooth, replacing filling, stopping pain. The more information you provide, the easier it will be to meet your expectations

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Date of birth____/_____/_______

Patient Name:___________________________________

Patient Signature :__________________

Date of Signature____/_____/________