chase lodge dental

Your personal details

Please print, complete, scan and return to info@chaselodgedental.co.uk

Welcome to Chase Lodge Dental Practice, we are regulated by The Care Quality Commission London, Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA – telephone 03000 616161. Please confirm the following information to ensure we have recorded this correctly on your records.

Title *(Mr, Mrs, Miss, Ms, other title):*	
First name(s) *(please include all forenames in full):*	
Surname:	
Address:	
	Postcode:
Date of birth: D D M M Y Y Y Y	
Home telephone number:	Work telephone number:
Mobile telephone number:	Email address:
Occupation:	
How did you hear about us?	

Details of contact in case of emergency

Name:
Telephone Number:

Insurance details

Are you insured for any dental care?	X Yes X No (optional)
If yes, under which insurer or plan? Membership number (if applicable):	

Medical history questionnaire – confidential

Please fill in this section carefully. It is important that your dentist has your full medical history. Please ask your dentist's advice if you are unsure about any of the questions.		
GP name:		
Telephone number:		
Address:		
	Postcode:	
Have you been seen by your GP during the past year?	Yes [ ]	No [ ]
Are you presently under medical care or taking any medication (tablets, medicines or drugs)? If yes, please list in space provided at end of medical history section:	Yes [ ]	No [ ]
Are you taking or have you taken steroids in the last two years?	Yes [ ]	No [ ]
Have you ever had a prolonged illness or been hospitalised?	Yes [ ]	No [ ]
Have you tested positive at any time for COVID-19?	Yes [ ]	No [ ]
Have you had any major/serious operations or radiation therapy?	Yes [ ]	No [ ]

Medical history questionnaire (continued)

Do you have or have you had any of the following?								
Rheumatic fever	Yes ☐	No ☐	High blood pressure	Yes ☐	No ☐	Low blood pressure	Yes ☐	No ☐
Congenital heart lesion/ cardiac pacemaker	Yes ☐	No ☐	Asthma or hay fever	Yes ☐	No ☐	Hiatus hernia/ stomach trouble	Yes ☐	No ☐
Heart attack/ angina/stroke	Yes ☐	No ☐	Jaundice, hepatitis, liver disease	Yes ☐	No ☐	Diabetes – low blood sugar	Yes ☐	No ☐
Heart murmur	Yes ☐	No ☐	HIV/AIDS	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐
Bone or joint disease	Yes ☐	No ☐						

Do you have or have you had any contact with Hepatitis or HIV/AIDS carriers which is likely to put you at risk from either of these viruses?	Yes ☐	No ☐
Did you as a child or since have brain surgery, growth hormone treatment before the mid-1980s or have a close relative with CJD?	Yes ☐	No ☐
Have you ever had any ill effects following dental treatment?	Yes ☐	No ☐
Have you or any relation had any severe prolonged bleeding problems?	Yes ☐	No ☐
Have you any allergies to medicines ie penicillin, substances or materials (latex/rubber)?	Yes ☐	No ☐
Have you had any ill effects from any other antibiotic?	Yes ☐	No ☐
Have you had any ill effects from local anaesthetic?	Yes ☐	No ☐
Have you ever had any ill effects from aspirin?	Yes ☐	No ☐

Do you smoke any tobacco products or chew tobacco, pan/betel nut or other similar products? If yes, how many a day? cigarettes	Yes ☐	No ☐
Have you previously smoked?	Yes ☐	No ☐
Do you drink alcohol? If yes, approximately how many units per week?	Yes ☐	No ☐
The next two questions are applicable to women only.		
Are you pregnant or is it possible you may be pregnant?	Yes ☐	No ☐
Are you taking contraceptive pill? Certain medication may compromise its effectiveness.	Yes ☐	No ☐
Is there any other information about your medical history which may be important? If yes, please list below.	Yes ☐	No ☐

Please list your current medications:

Dental history

What prompted you to seek dental care at this time?		
How long is it since your last thorough dental examination with X-rays?		
What words best describe your past dental experiences? ☐ Caring ☐ Relaxed ☐ Modern ☐ Painful ☐ Stressful ☐ Sympathetic ☐ Rushed ☐ Good value ☐ Uncomfortable ☐ High-tech ☐ Old Fashioned ☐ No choice		
Has the fear of discomfort kept you from regular visits?	Yes ☐	No ☐
Have you experienced any discomfort in your teeth recently?	Yes ☐	No ☐
Are you aware of any grinding or clenching of your teeth?	Yes ☐	No ☐
Do your jaw joints ever hurt or click?	Yes ☐	No ☐
Do you suffer from headaches or migraine pains in your face or your ear?	Yes ☐	No ☐
Do your gums bleed easily, feel tender or irritated?	Yes ☐	No ☐
Are you troubled with bad breath or a bad taste?	Yes ☐	No ☐

Dental history (continued)

Would you like to know more about any of the following?

Teeth whitening: ☐ Yes ☐ No

Replacing missing teeth: ☐ Yes ☐ No

Teeth straightening: ☐ Yes ☐ No

Softening lines/wrinkle reduction: ☐ Yes ☐ No

Data Information

All appointments must be paid at the time of your visit or in advance. Our basic fees are displayed on-line and at Reception, but should you require further treatment the dentist will discuss this with you directly.

I understand a minimum of 48 hours notice must be given to change or cancel an appointment. A cancellation fee of 50 percent of your treatment cost will apply if changes are made with less than 48 hours notice.

HOW WOULD YOU LIKE TO RECEIVE INFORMATION? (you may tick more than one option):

EMAIL ☐ TELEPHONE ☐ TEXT ☐ BRAILLE ☐ LARGE FONT ☐

In signing this form, you consent to Chase Lodge Dental sharing your identifiable information (contact details and date of birth) with Doctors, hospitals, health care professionals and healthcare providers in order to provide you with dental services. All such referrals would be discussed with you in advance at a consultation. We never share details with any party for the purpose of advertising or marketing or any other purposes other than providing you with dental services at your request.

I have read and understood the above.

Patient signature (or parent/guardian signature if under 16):

Date: D D M M Y Y Y Y

Dentist/dental professional signature:

Date: D D M M Y Y Y Y