FINEDON DENTAL PRACTICE

Welcome Letter

Dear Patient,

We at Finedon Dental Practice are delighted that you have made an appointment with one of our Dentists or Hygienist. **Please complete and sign all forms and give back to Reception.**

Making appointments

We aim to arrange appointments at times that are convenient; we have early morning and late evening sessions on Tuesdays and Wednesdays.

Appointment Policy

We understand that appointments may have to be cancelled or altered from time to time. If you are unable to keep an appointment, please give as much notice as possible so that we can offer it to another patient. If you give us less than 24 hours' notice, we may make a charge of £120 per hour. (*Note: late cancellation charges do not apply for NHS patients however missed appointments may result in being moved back on to the NHS waiting list*).

Regular Attendance

To achieve and maintain good oral health it is important to attend regular check-up exams and any additional associated treatment appointments advised by your Dentist. Non-attendance may result in you losing your right to emergency appointments. We make every effort to send out appointment reminders via SMS and email providing we hold up to date information. It is your responsibility to ensure you attend your appointments and update your information accordingly. We ask that you arrive at least 5 mins early for each visit to check in with reception and update any necessary information.

If you are exempt from NHS charges then proof of exemption must be brought to each appointment otherwise you may incur a charge according to NHS guidelines. Please be aware we are contracted to only see NHS exempt patients.

Your information

The practice follows agreed procedures to keep your information secure and private. For more information, please see our Privacy Notice published on our website or from Reception.

Medical History

We ask all patients to fill out a registration form and medical history form when you join the practice which requires a date and signature. We will update your medical history at the beginning of each course of treatment. Many medical conditions or medications can have an effect in the mouth so it is vitally important that we are aware of any indications that may affect the dental care we provide to you. Please remember to bring your medication list to each appointment in order to inform the Dentist/Hygienist of medications, dosage, frequency and the reason for taking the medication.

P.T.O

FINEDON DENTAL PRACTICE

Payment

We will make sure that you know the cost of your dental treatment and agree to it before we start any treatment. We will give you a written treatment plan and estimate of costs where the treatment is extensive or costs more than £70.00

You may pay for your dental care by *cash, debit or credit card* or join one of our practice dental plans. We try to make payments as straightforward as possible for our patients. Our normal practice policy is that *you pay a proportion of the costs at the end of each visit* or *you pay the full cost of treatment before we start*.

Please indicate the type of dental care you would like to receive:

Private Plan ☐
Private Pay As You Go Plan ☐
NHS ☐
If you have ticked NHS, please be aware of the waiting list and make sure you are aware of possible waiting times and specific criteria.

Emergencies

If you need urgent treatment during normal surgery hours, you should contact the practice for advice. If you need to be seen by a dentist, we will arrange an early appointment – where possible, on the same day. If you need urgent advice when the practice is closed, you should telephone **Northfield Dental Practice on 01536 525436 or 111 for the out of hours NHS service for advice**.

Data Protection

The Data Protection Act 1998 prevents any person or organisation from accessing or sharing personal information on an individual without their express permission. Should you wish for another individual living at your current address to be able to make/amend/discuss your dental appointments/information on your behalf, please confirm below.

Yes ☐ Their name/s ……
No ☐

Feedback

We hope that you will be satisfied with the dental care and services that you receive from our Clinicians at the practice. If you have any feedback on the care or service that you have received, please contact any member of staff who will be able to guide you through our complaints/feedback procedure.

If you have any queries about the content of this letter, please feel free to contact any member of staff.

Yours sincerely

Finedon Dental Practice Team

Patient Signature …… Date …….....

Please complete and sign all forms and give back to Reception.

FINEDON DENTAL PRACTICE

Personal Details: (Mr/Mrs/Miss/Ms/Other) Please state ……..
Surname: …… First name: ……

Address: ……

……

Postcode: …… Date of Birth: ……

Telephone Number: …… Mobile Number: ……

Email: ……..

Occupation: ……

I authorise Finedon Dental Practice to communicate with my next of Kin/ carer/ power of attorney* (please delete as appropriate)

Their name: ……

Relationship: ……..

Their contact number: ……
*If you have selected Power of Attorney, please complete a Mental Capacity form.

Permitted use of personal data

☐ In the event that any person working at Finedon Dental Practice wishes to use any of my personal data for use for marketing, promotional, educational, training or any other purpose than my care & treatment, I permit the practice management to make an information request to me using the following method. Text ☐ Email ☐ Phone ☐ Letter ☐

☐ I DO NOT permit the practice management to request using my personal data for any purpose other than my care & treatment.

Certain medical conditions can affect dental treatment and vice versa.

Please complete the medical history form.

FINEDON DENTAL PRACTICE

MEDICAL HISTORY

	Yes	No
COVID-19 TRIAGE. Do you currently have Covid 19?	☐	☐
If you smoke, what is your average per week?	☐	☐
What is your average weekly consumption of alcohol?	☐	☐
Please tick or tell the dentist if you are HIV positive	☐	☐
Have you ever had a joint replacement operation?	☐	☐
If yes, please give details		
In the past 2 years have you been treated with hydro-cortisone or corticosteroids?	☐	☐
In the past 2 years have you undergone any operations?	☐	☐
If yes, please give details		
Are you at present taking any medicine or tablets? *Please list below*	☐	☐
Are you allergic to any medicine, tablets, substances or latex? *Please list below*	☐	☐
Do you carry a medical warning card?	☐	☐
Do you have or have you ever suffered from any other serious illness?	☐	☐
If yes, please give details		
Do you have or have you ever suffered from high blood pressure?	☐	☐
Do you have or have you ever suffered from excessive bleeding?	☐	☐
Do you have or have you ever suffered from hepatitis?	☐	☐
Do you have or have you ever suffered from chronic bronchitis or asthma?	☐	☐
Do you have or have you ever suffered from epilepsy or fainting attacks?	☐	☐
Do you have or have you ever suffered from diabetes?	☐	☐
Do you have or have you ever suffered from any heart complaint, heart surgery or stroke?	☐	☐
If yes, please give details		
Are you pregnant?	☐	☐
Do you have or have you ever suffered from rheumatic fever?	☐	☐

Please include the name and address of your doctor .....

.....

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING

.....

.....

.....

.....

PLEASE LIST ANY ALLERGIES

.....

.....

.....

.....

FINEDON DENTAL PRACTICE

MEDICAL HISTORY (continued) YES NO

Do you have any problems being given a local anaesthetic? ..... ☐ ☐

Do you have any problems being reclined in the dentist chair? ..... ☐ ☐

Do you need anti-biotic cover before treatment? *You will already be aware of this should you need it.* ☐ ☐

If yes, please give details .....

Do you have any other medical information or any other important information about your medical history that has not already been included? ..... ☐ ☐

If yes, please give details .....

.....

If you are unsure of any questions, or if any of your medical circumstances change at any time, please speak to the Dentist

Patient Signature ..... Date .....

Smile Assessment

How happy are you with your smile?

Very happy Happy Satisfied Could be better




What do you tend to drink most of?

Water	☐				
Milk	☐				
Tea / Coffee	☐	with sugar	☐	without sugar	☐
Squash	☐	with sugar	☐	without added sugars	☐
Fizzy drinks	☐	with sugar	☐	without sugar	☐
Other	☐				

Are you interested in preventative dental care and keeping your teeth for life?

Yes ☐ No ☐

Which toothpaste do you currently use?

Do you currently clean between your teeth?

Yes ☐ No ☐

If yes, which oral health products do you use?

FINEDON DENTAL PRACTICE

General Consent

PLEASE READ THIS FORM CAREFULLY. SHOULD YOU HAVE ANY QUESTIONS, OUR STAFF WILL BE HAPPY TO HELP YOU.

1. I hereby authorise and direct the dentist and/or dental assistants to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

2. Dental photography/videos: this data is used for dental records, dental research, dental education including lectures, seminars, demonstrations and professional publications (books and journals), marketing material (website, social media, promotions and patient education). If your photographs are used, your name and other information will be kept confidential at all times, unless full face photos are used with your consent (e.g. for testimonials). Patients should not expect compensation, financial or otherwise for these photos, you have the right to withdraw your consent at any time. Yes ☐ No ☐

3. I understand x-rays, photographs, models or the mouth and/or other diagnostic aids used for an accurate diagnosis and treatment are the property of the dentist but copies of certain aids are available upon request for a fee.

4. In general terms, the dental procedure(s) can include but not limited to:

   * Comprehensive oral examination, radiographs, cleaning of the teeth and the application of topical fluoride.
   * Application of resin sealants to the grooves of the teeth.
   * Treatment of diseased or injured teeth with dental restorations (fillings).
   * Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or infections.

5. I understand that the dentist is not responsible for the previous dental treatment performed in other practices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realise that the guarantees of results or absolute satisfaction are not always possible in dental health service.

6. I have answered all of the questions about me or my dependent's medical history and present health condition fully and truthfully. I have informed the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s) I will inform the practice at the next appointment or earlier.

I hereby acknowledge that I have read and understand this content and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this content shall remain in effect until terminated by me.

Patient Name	Date of Birth
Parent/Guardian *if applicable*	Relationship
Signature	Date

FINEDON DENTAL PRACTICE

Informed Consent

1. **Drugs and Medication:** I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (*severe allergic reaction*) Initials .....
2. **Changes in Treatment Plan:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give permission to the dentist to make any/all changes and additions as necessary once they have been discovered and discussed. Initials .....
3. **Removal of Teeth:** Alternatives to removal will be explained to me (root canal therapy, crowns, dentures, and periodontal surgery etc) and I will have the choice of the best procedure for me. I understand removing teeth does not always remove all of the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some which are in pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months), or fractured jaw. I understand I may need further treatment by a specialist or even hospitalisation if complications arise during or following treatment, the cost of which is my responsibility. Initials .....
4. **Crowns and Bridges:** I understand that sometimes it is not possible to match the colour of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realise the final opportunity to make changes in my new crown/bridge (including shape, fit, size, colour) will be before cementation. Initials .....
5. **Endodontic Treatment (Root Canal Treatment):** I realise there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment and that occasionally metal objects are cemented in the tooth or extended through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicectomy). Initials .....
6. **Periodontal Loss (Tissue & Bone):** I understand that periodontal disease is a serious condition, causing gum and bone infection or loss and that it can lead to loss of my teeth. Alternative treatment plans will be explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. Initials .....
7. **X-Rays:** I understand x-rays are needed for proper diagnosis treatment. Initials .....
8. **Dentures, Complete or Partials:** I realise that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems with wearing these appliances has been explained to me, including looseness, soreness and possibly breakage. I realise the final opportunity to make changes to my new dentures (including shape, fit, size, placement & colour) will be the 'teeth in wax' try-in visit. I understand that some dentures require relining approximately 3 to 12 months after initial placement. The cost for these procedures are not included in the initial denture fees. I understand wearing dentures is difficult and there are common problems such as sore spots, altered speech and difficulty eating. Immediate dentures (placement of dentures immediately after extractions) may be painful, will require considerable adjustments and several relines and a permanent reline will be needed later; or a new partial or completely new denture; this is NOT included in the denture fee. It is important to make all necessary impression, try-in and delivery appointments, failure to make these appointments can result in poorly fitting dentures and the need to remake them, resulting in additional charges. Initials .....

FINEDON DENTAL PRACTICE

Informed Consent (continued)

9. **Filling:** I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more expensive filling may be required due to additional decay than what could be seen by the x-ray and that significant sensitivity is a common after effect of a newly placed filling.

Initials …….

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorised. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Patient Name	Date
Parent/Guardian *if applicable*	Relationship
Patient Signature	
Dentist Signature	Date

Please complete and sign all forms and give back to Reception.