CONFIDENTIAL MEDICAL HISTORY FORM

Where did you learn about the practice?.....

SURNAME …….....FIRST NAME …….
TITLE …….. Sex M [ ] F [ ] D.O.B ……..
ADDRESS……
POST CODE ……HOME NUMBER …….
MOBILE……..... E-MAIL.....……...
Occupation ……

DOCTORS NAME …… TELEPHONE …….
ADDRESS ……

NEXT OF KIN (name & contact number).....

Smile and facial aesthetic Questionnaire
(please circle)

- Do you have concerns about your breath? **Yes** **No**
- Would you be interested in tooth whitening? **Yes** **No**
- Are you concerned with crooked or crowded teeth? **Yes** **No**
- Would you like to improve the look of your smile? **Yes** **No**
- Do you get food trapped between your teeth? **Yes** **No**
- Do your gums bleed when you brush your teeth? **Yes** **No**

I understand and agree with the following practice policies:

- ✓ That the agreement by which I will be given dental treatment (my treatment plan) is an agreement between the dentist and me.
- ✓ That under my Treatment Plan, my treatment will have to be paid for in total by the last visit.
- ✓ That under my Treatment Plan, I may be required to pay in advance for certain items of treatment.
- ✓ That under my Treatment Plan, I may be charged a fee of £15 for each 15 minutes of an appointment missed or a £20 late cancellation charge if cancelled without a full working days' notice prior for **private** dental visits and half the hygiene fee (£32.50) for **hygienist** visits.
- ✓ That if I miss more than two **NHS** appointments or fail to give a full working days' notice it will result in you no longer being seen at the practice.

Signed……..**Date**……..

Please complete the questionnaire overleaf

Practice use only
Medical History checked

Dentist..... Date ..... Signed.....
Dentist..... Date ……..... Signed.....
Dentist..... Date ……..... Signed.....