**We ask you for information about your general health to help us treat you safely. All information will be kept strictly confidential. Please can we ask that you download a copy of this document to your device, complete this questionnaire in full and carefully return it to the email address it was sent from.**

Title: Surname: First name/s:

Address:

Postcode: Telephone - Home: Mobile: Email: Date of birth: Emergency Contact:

Emergency contact number:

Doctor’s surgery name: Occupation:

Have you attended St. George’s Dental Practice before?

How long is it since your last dental visit?

During these uncertain Corona Virus/Covid-19 times we are following the advice of the Chief Dental Officer for England. Their advice is to try to keep to keep direct dentist to patient contact to a minimum.

Unfortunately, for the time being we are not able to carry out routine treatment. We are running a phased return to dentistry and can only provide limited services but we will do what we can to make you more comfortable.

An advice call will be placed with a dentist in the practice. The dentist will talk to you about your symptoms. If they think that your problem can be made better with a prescription or advice that will be provided to you.

If the dentist issues a prescription it can be picked up from the Superdrug Pharmacy in Canterbury City Centre after 3pm the day of the advice call. You should tell the pharmacist that it is a prescription from the dentist.

If the dentist thinks that an appointment needs to be made they will get you booked in. Our reception staff will then explain the process for attending the practice and take payment if required.

Advice call slots are limited. Should you fail to answer your telephone we cannot guarantee we will be able to call again. Reception will be able to advise you of the approximate time of your call.

**Covid 19 assessment.**

**Please fill in below by putting an X in the relevant answer box and providing additional information where relevant.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Comment |
| Have you had any symptoms of the following in the last 7 days? |  |  |  |
| New continuous cough? |  |  |  |
| High temperature over 37.8 degrees Celsius or fever? |  |  |  |
| Loss of taste or smell? |  |  |  |
| Have you tested positive for Covid 19 in the last 7 days? |  |  |  |
| Are you waiting for a Covid test result? |  |  |  |
| Do you live with someone who has either tested positive or had symptoms in the last 14 days? |  |  |  |
| Have you been notified by track and trace in the last 14 days or has someone in your household been notified that there has been contact with a Covid 19 positive person? |  |  |  |

**Vulnerability assessment.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Comment |
| Have you been issued with a government shielding letter? |  |  |  |
| If so, what is the date you can resume normal activities? |  |  |  |
| What is the condition that makes you vulnerable to Covid 19? |  |  |  |
| Are you over 70? |  |  |  |
| Are you pregnant? |  |  |  |
| Would the patient need access to the downstairs surgery? |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **In the last 2 years, have you:** | Yes | No | Details: |
| Attended or received treatment from a doctor, hospital clinic or specialist? |  |  |  |
| Taken any prescribed medicines from your doctor (e.g. tablets, ointments, injections or inhalers)? |  |  |  |
| **Have you ever had:** | Yes | No | Details: |
| Allergies to medicines, foods or materials (e.g. latex/rubber)? |  |  |  |
| Rheumatic Fever? |  |  |  |
| Heart trouble? |  |  |  |
| High Blood Pressure? |  |  |  |
| Asthma? |  |  |  |
| Arthritis? |  |  |  |
| Hepatitis A, B, or C? |  |  |  |
| Bronchitis or Chest Problems? |  |  |  |
| Severe Headaches? |  |  |  |
| Epilepsy? |  |  |  |
| Anaemia? |  |  |  |
| Diabetes? |  |  |  |
| Kidney Trouble? |  |  |  |
| Gastric Problems? |  |  |  |
| Cold Sores? |  |  |  |
| Mental Health Problems? |  |  |  |
| Prosthetic surgery? |  |  |  |
| Any other conditions we should know about? |  |  |  |
| **Are you:** | Yes | No | Details: |
| Pregnant? |  |  |  |
| HIV positive? |  |  |  |
| At risk to HIV exposure? |  |  |  |

**Please fill in below by putting an X in the relevant answer box and providing additional information where relevant.**

**Please indicate by placing an** X **in the relevant answer box and providing additional information where relevant.**

1. Do you drink alcohol? If yes, how many units do you drink?

Yes  No units per week

(A unit is half a pint of lager, a single measure of spirits or a single glass of wine/aperitif).

1. Do you smoke any tobacco products now (or did you in the past)?

Yes, No times per day

1. Do you take any recreational drugs?

Yes  No Details:

*Please note that if you are under the influence of substances, we may refuse to see you due to safeguarding and consent issues*

**Dental History:**

1. Do you have dental pain or a dental problem at present?

Yes, No Details:

1. Have you ever experienced excessive bleeding or bruising?

Yes, No Details:

1. Do you become anxious or uncomfortable when you are having dental treatment?

Yes, No

*Please note our dental chairs have weight limits of 21 stone (133kg) if you feel that this is an issue, please alert your dentist in confidence.*

**Please type your name next to signed. This will be accepted as a digital signature.**

Declaration:

I declare that I have read and understood the information that I have received today and that the information I have provided is correct. I understand that any paperwork I would normally sign will be signed on my behalf by a member of staff and that I can request copies of the paper via email.

**Signed:** Patient/Parent/Guardian Date: