|  |
| --- |
| **Title First Name Last Name** **Male/Female DOB .........../............./....................** |
| **Email Address****(For reminders and online booking) ............................................................@.............................................****Do you require a translator? (Yes/No) If yes which language.......................................** |
| **Address****Postcode** |
| **Home Telephone Mobile****Work Telephone Occupation****Emergency Contact Name/Relationship/Contact Number** |
| **Doctors Name/Address (All patients must complete):****Name of Current School (If applicable):** |
| **Please answer all questions in full** | No | Yes: Give details |
| Are you attending a doctors, hospital or specialist? |  |  |
| Taking any prescribed medicines? List in full overleaf if needed |  |  |
| Do you have a mental or physical disability?If yes, is there a way we can make your visit easier? |  |  |
| Are you taking any steroids? or taken any in the last 2 years? |  |  |
| Do you have any allergies? (e.g. Penicillin, Latex)Do you have Hay fever or Eczema? |  |  |
| Do you have or have you had Hepatitis, Liver disease, Kidney disease? |  |  |
| Have you ever been told you have a heart murmur, heart problem, angina, suffered a heart attack or high blood pressure? |  |  |
| Had any recent blood tests? ? Or had your blood refused by the Blood Transfusion service? |  |  |
| Are you pregnant? |  |  |
| Had a bad reaction to a general or local anaesthetic? |  |  |
| Have arthritis? Had a joint replacement?Do you need a downstairs surgery for medical reasons? |  |  |
| Suffer from bronchitis, asthma or other chest condition? |  |  |
| Have fainting attacks, giddiness, blackouts or epilepsy? |  |  |
| Have diabetes? |  |  |
| Bruise easily or persistent bleeding after injury? |  |  |
| Do you have any infectious diseases such as HIV?Do you carry a medical warning card? |  |  |
| Do you smoke? If yes how many cigarettes do you smoke on average in a day? How long have you been a smoker? Or do you chew any Tobacco products? |  |  |
| Do you consume alcohol?On average how many units a week? |  |  |
| Completed by: Self/Parent/Guardian Name: SignatureThis **MUST** be completed by the patient if 16 years or older (Unless completed by a named carer) |

**To process your appliaction Please provide Proof of ID.**

An initial check-up is a requirement for the Denplan service. After which a full estimate and treatment plan will be provided. A check up and x-rays is £50.00 for adults and £35.00 for children.

General appointments will initially be on our Saturday clinic with Dr Uzma Rajah

I understand that this is a private appointment and not NHS..

I understand a £20.00 deposit is payable when booking, and will be deducted from the check-up fee.

A failure to attend will mean a failed booking charge. All cancellations and rebookings must be given 48hrs in advance and may be subject to admin charges. Cancellations or rebookings due to covid will require a positve PCR test.

**Signed…………………………………………………………..**

**Name…………………………………………………………….**

**Date……………………………………………………**

**email completed form to** **info@151dental.co.uk**

**Phone landline 0161 872 1695**

An estimated guide to costs is

Filling cost £65.00 to £150.00 (per filling)

Crown Cost £450.00 to £650.00 (per crown)

Dentures £550.00 to £850.00 (per denture)

Root canal treatment £250.00 to £450.00

Scaling/cleaning £59.00 (per visit)