

**CONFIDENTIAL MEDICAL HISTORY FORM**

To obtain the best and safest treatment, your dentist needs to know of any problems which may effect your treatment. Please complete as much as possible. If you are unsure of any answers, please discuss with your dentist.

FULL NAME: (Mr/Mrs/Miss/Ms) .....DATE OF BIRTH:.....

ADDRESS:.....

.....POST CODE:.....

TELEPHONE:(HOME):.....(MOBILE):.....(WORK):.....

DENTAL INSURANCE YES/NO                      OCCUPATION .....

HOW DID YOU HEAR ABOUT US .....

SMOKER YES/NO                                      UNITS OF ALCOHOL PER WEEK .....

EMAIL ADDRESS:..... DOCTOR.....

	Yes	No	Details
Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?			
Have you ever been told you have a heart problem, Angina, raised blood pressure, heart attack or heart murmur?			
Do you have a pacemaker, or have you had any form of heart surgery?			
Do you have diabetes?			
Have you had jaundice, hepatitis or any other liver or kidney disease?			
Do you bruise easily or have you suffered from excessive bleeding following an injury or any form of surgery or tooth extraction?			
Have you suffered any complications during or after a tooth extraction; eg difficult extraction, infection?			
Do you have fainting attacks, giddiness, blackouts or epilepsy?			
Do you suffer from any allergies to medicines, food or materials?			
Have you had a bad reaction to a general or local anaesthetic?			
Are you pregnant?			
Are you taking or have you taken steroids in the last 2 years?			
Are there any other aspects concerning your health that you think the dentist should know about?			
Are you taking any medicines prescribed by your doctor or of your own accord?			
Do you have any infectious diseases (eg TB, HIV or Hepatitis)?			

Completed by: Self/Parent/Guardian; I undertake to settle all fees when due either at the time of treatment or in advance. I understand that interest may be paid on overdue accounts and that seriously overdue accounts may incur extra fees. If treatment is to be paid by a third party i.e. under insurance or under Guernsey Social Security I remain liable for those fees until the account is settled. I am aware that if I late cancel or fail to attend an appointment I may be charged.

Signature:..... Date:.....

## General Dental Fees 2017

### General Dentistry

Initial Consultation	£ 100
Routine Check-Up (6 monthly)	£ 55
Bite-Wing X Rays	£ 45
Bridges	<i>from</i> £1365
Crowns – Bonded Porcelain	<i>from</i> £ 795
Dentures F/F Acrylic	£ 1750
Dentures Partial	£ 900
Extractions	£ 150
Extractions Requiring Surgery	<i>from</i> £ 250
Root Fillings – Single Rooted Teeth	<i>from</i> £ 450
Implant Retained Crown	£ 1400
OPG X Ray or Lateral X Rays	£ 65
White Fillings – Simple One Surface	<i>from</i> £ 100
White Fillings – Extensive Three + Surface	<i>from</i> £ 250
Veneers – Per Tooth	£ 795

### Cosmetic & Specialist

Botox or Dermal Fillers	<i>from</i> £ 200
Nutritional Consult or Psychotherapy	£ 100
Orthodontic Consult for Children	FREE
Orthodontic Consult for Adults	£ 95
Somnowell Device (Snoring)	£ 1700

### Dental Hygienist

Scale & Polish (30 minutes – Includes Gingival and Periodontal Assessment)	£ 70
Deep Scale and Root Planing (60 minutes)	£ 140
Phillips In-Surgery Whitening	£ 695
Tooth Whitening Trays & Kit	£ 395

### Emergency Consultations

Emergency Consultation during Surgery hours	£ 55
Emergency Call Outside of Surgery Hours*	£ 250

\*(Out of normal surgery hours, 18h00 to 8h00. Weekdays, weekends and bank holidays. Fee may exclude the cost of any work done at the appointment.)

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date