Orchard House
DENTAL CARE

Welcome to Orchard House Dental Care

Thank you for choosing us for your Dental Care. Our aim is to provide high quality care to all, in a modern, safe and comfortable environment. We respect and understand that each of our patients are individuals; and we therefore strive to tailor our care and treatment to each person's needs, wants and often limitations!

We understand many people are anxious about visiting the dentist, especially if they haven't attended for some time, and we will always do our best to put you at ease and make the experience as pleasant as possible. Your first dental appointment with us usually takes around 20 minutes, and will allow us to introduce ourselves and discuss any concerns or questions you may have. We will cover your medical history and carry out a complete examination of your oral health, including a visual screen for oral cancer, and x-rays if appropriate. If we identify a need for further treatment this will be explained, with any costs involved given. If required we can refer to colleagues for treatments we do not offer, such as Sedation. We will also, if requested, advise you which Dental Plan may suit your needs and requirements.

We offer 2 types of Plan: Basic and Routine where you would pay a monthly fee, and they differ by the frequency of check-ups and treatment included. In order to join the most suitable plan we recommend you discuss this with your dentist at your New Patient Exam appointment.

Once you are dentally fit after your inital New Patient Exam and any necessary treatments, to help you decide whether to stay as a Fee-per-Item patient or become a DPAS Plan member, please see the Private Fee list and Plan comparison on our Website, under Dental Treatment Prices.

To arrange your first visit you can call in person, telephone, email or use the 'Contact Us' page. We will be happy to take your details and arrange a convenient appointment. If once made you are unable to keep your appointment, please be so kind as to let us know at least 24 hours beforehand, so your slot can be reallocated to another patient.

A Medical History form is given below. Please be so kind as to print a copy, complete both pages and bring to your first appointment to avoid delaying you longer than necessary, or alternatively call into the Practice to be sent a copy. If you have a long list of medications, please bring a recent prescription, so we may add them to your records.

If you have any further questions or queries, please do not hesitate to contact us.

We look forward to meeting you.

With Kind Regards,

Stephanie & David
Practice Owners

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Orchard House Dental Care
Confidential Medical History Form

To obtain the safest treatment, your dentist needs to know of any health problems that may affect your treatment

Title: Name:	Date Of Birth:
Address:	
Post Code:	Tel/Mob No:
Work/School Tel:	Occupation:
Email:	
How would you like to be contacted - by phone/email/text/post ?:	
Doctors Details:	
Emergency Contact/Next of Kin details:	

IF YOU ANSWER 'YES' TO ANY OF THE FOLLOWING, PLEASE GIVE DETAILS

ARE YOU:	Y	N	PLEASE SPECIFY:
Under treatment from a doctor, hospital or clinic?			
Taking any medication (tablets, injections, other?)			
Taking or have taken steroids in the last two years?			
Allergic to anything?(medicines, materials etc)			
Pregnant or Possibly Pregnant?			

HAVE YOU EVER:	Y	N	PLEASE SPECIFY:
Had Rheumatic Fever or Chorea?			
Had Hepatitis?			
Had Jaundice, Liver or Kidney disease?			
Had a Heart Attack or been told you have Angina?			
Had High/Low Blood Pressure?			
Had recent blood tests, inoculations etc?			
Had your blood refused by the blood transfusion service?			
Had any Lung or Breathing problems? (Asthma, COPD)			
Had a joint replacement?			

DO YOU:	Y	N	PLEASE SPECIFY:
Have a pacemaker, or had any form of heart surgery?			
Any Implants? (not just dental)			
Have regular fainting attacks, giddiness, blackouts **OR** Epilepsy?			
Have diabetes or any ***blood relative*** in the family?			
Bruise easily or bleed excessively following a tooth extraction, surgery or injury, so as to cause you to worry?			
Have **Rheumatoid** Arthritis?			
Carry a warning card?			
Ever get cold sores? if so How Often?			
Is there anything else that you feel your dentist should know - e.g. history of difficult extractions?			

Do you regularly consume more than 2 units of alcohol/day **OR** 'Binge' drink?
Have you/Do you smoke? If so, how many per day?

(1unit, approx 1/2 of pint of beer or small glass of wine)

Completed by: Signature.....Self/Guardian/Parent

Date.....

How would you like to hear from us for your reminders & confirmations?

☐ Email ☐ Text ☐ Letter ☐ None

When did you last see a dentist?_____ **Hygienist?**_____

How did you hear about us?

☐ Social Media ☐ Advertisement

☐ Personal recommendation (word of mouth)
If it was a personal recommendation please tell us who, we would like to say thank you: _____

☐ Internet (Google etc) ☐ Other _____

☐ Previous Patient

To help us provide the Best Care, please indicate below which Treatments Interest You

☐ Regular Routine Dental Checks & Maintaining Good Oral Health

☐ Clean Teeth/Fresh Breath

☐ Treatment of Pain

☐ Teeth Whitening

☐ Straightening Teeth, Orthodontic Treatment

☐ Facial Aesthetics - Botox, Wrinkle Reduction, Sweating Treatment etc

☐ Improving the Look of Your Smile - Cosmetic Treatment

☐ Other_____

Do you have any concerns that you would like the dentist to be aware of?

Gingival (gum) health has an impact on dental and also General Health Do you suffer from, or are you overly concerned about, any of the following:

☐ Bleeding gums ☐ Bad breath or bad taste in your mouth

☐ Difficulty flossing ☐ **Excessive** tooth sensitivity to hot, cold, sugar or pressure