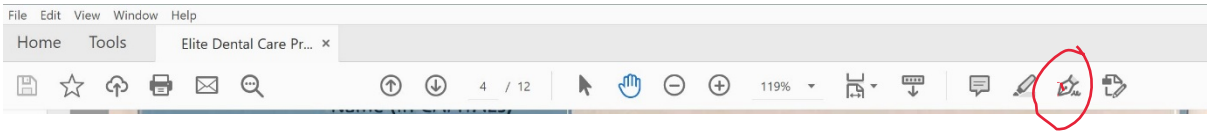
ELITE DENTAL CARE PRE-APPOINTMENT PAPERWORK GUIDANCE

So that we can perform procedures as safely and efficiently as possible, before you attend the practice you **must fill in all of the forms below. After being completed, forms must be emailed to elitedentalfinchley.dentist@nhs.net - they cannot be handed in personally to reduce the spread of bacteria once you are on site. Only once these steps are completed will you be able to attend your appointment.**

Below is a guide to filling out and sending off your medical and consent paperwork. If you require further advice, please contact the surgery on 02083468717 or 02082027216.

Once you have downloaded the PDF document onto your computer, when clicked it will automatically open in Adobe Reader.



Selecting the circled icon from the menu bar will allow you to edit text within the PDF. A text box will be created as you move your cursor, which you can type your information into.

Red X's are marked throughout the document where your name, signature (can be your name typed) a cross or date are required. You do not need to fill out any other information at this time.

Every page contains guidance at the top in red, informing you of what and whether you need to sign.

*****Please note. For the NHS Patient Declaration on Pages 3 &4, Page 3 must be signed and dated by ALL NHS PATIENTS. Only patients that do not pay for their dental treatment must sign, date and cross Page 4 .**

Once you have filled in and signed the document in all the relevant pages, select Save As and save the file as your full name. Then attach this to an email, and send to **elitedentalfinchley.dentist@nhs.net.**

Elite Dental Care

What We Are Doing to Keep You and Our Team Safe.

We are excited to have the opportunity to welcome you back! Our Practice has always utilized personal protective equipment (PPE) that has exceeded all the CDC guidelines, however, in light of the COVID-19 Pandemic we have instituted additional guidelines and protocols to ensure your safety.

You will see many changes, as we have new ways of scheduling appointments. First patients will be contacted prior to their appointment via phone and asked a set of health-related questions. It is required that we complete this questionnaire prior to the appointment. **We will have to reschedule the appointment if we are unable to complete this step.** Below is a list of some of the enhanced precautions we have taken to protect everyone's safety in addition to extensive team training on infection control and patient management procedures.

1. Please try and attend on your own whenever possible.

2. We may not be able to offer the washroom facilities. Please be mindful of this policy.

3. Arrival procedure to guide you from your car directly to treatment rooms to eliminate contacting surfaces.

4. Maintain distancing in the reception area for essential caregivers and parents of minors if they cannot wait from your car/ or if you are outside the surgery.

5. Removed magazines and items that can harbor or transfer germs of any kind. Hand sanitizers will be positioned throughout the clinic.

6. Providing more education materials to enhance your awareness of health issues related to this pandemic.

7. Installed screens at all reception areas to protect staff.

8. Require hand washing and hand sanitizing before all appointments by our team and by our patients.

9. Record temperature of every patient upon entering the Surgery.

10. Record the temperature of every team member each day at beginning of work period.

11. Payment arrangements in advance or afterwards to avoid delay and allow contactless exit from the appointment in the initial period.

12. Enhanced operatory disinfection procedures of all surfaces between patients.

13. Enhanced Surgery disinfection procedures before and after all appointments with mist or fogging devices to access hard to reach places that can be easily missed.

14. Superior personal protection equipment like visors, gowns, and masks for our clinical team to provide barriers against the smallest of germs.

15. Introduce protocols to reduce or eliminate airborne aerosols during all dental procedures.

16. Disinfection of all outside mail and packages that enter the building.

17. Longer appointment times for us to prepare and complete all appointment tasks and duties in the safest and most comprehensive manner.

Elite Dental Care

ALL PATIENTS MUST COMPLETE THIS FORM.

Full Name…… ……. …… **D.O.B**……

Address ……..**Postcode**……

Tel No: …… ……..**Mob**……

E-mail Address: ……..…….

GP details ……

Consent to disclose appt / treatment information with family member YES / NO
Preferred recall method : SMS , E-MAIL , LETTER
If you are an overseas visitor please speak to a member of staff

COVID 19 – HISTORY

Have you had COVID?.....

If so, have you had a swab or serum blood test to verify this?.....

Do you have any of the following symptoms currently: fever (37.5 or above), persistent cough or loss of smell or taste?.....

Where you reside, does anyone have COVID currently or any of the above symptoms?.....

Are you a shielded patient or shielding someone in the household?.....

MEDICAL HISTORY

Attending or receiving medical treatment?.....

Taking any medication? If so, then which ones…..…….....

Allergies to any medicines/ materials? ……

Bronchitis, Asthma , other chest condition?……

Hepatitis B, C ,or HIV?……

Had heart attack / Rheumatic fever/Endocarditis?……

Fainting attacks/Epilepsy/ Blackouts?…….

High Blood Pressure:? ……

Diabetes?…….... …… ……

Pacemaker?…….

Previous General Anaesthetic.....

Bruise easily , bleed excessively ,blood disorder?…….

Pregnant?……

Cigarettes smoked per day…….

Units of alcohol per week……

Signature……**X** **Date**…….. **X**

PATIENT PREFERRED CONTACT METHOD

ALL PATIENTS MUST COMPLETE THIS FORM.

I confirm that my contact details are correct and I would prefer to be contacted by this Dental Practice by the following method (please insert preferred method and details)

Home or mobile telephone number:
Email address:
Text/SMS message:
Letter Post:
Address:

If I am unable to speak/receive a message/read any correspondence I authorise the Practice to
Leave a message on this telephone number:

OR

Communicate with my Husband/Wife/Parent/Partner/Carer
Give Name:
Relationship:
Signed X **Date** X

Permitted use of personal data (STRIKE OUT CLAUSE A or B)

A) EITHER, In the event that any person working at ELITE DENTAL CARE PRACTICE wishes to use any of my personal data for use for marketing, promotional, educational, training or any other purpose than my care and treatment; I permit the practice management to make an information request to me using the following method: Specify how to be contacted here:

_____

B) I do not permit the practice management to request using my personal data for any purpose other than my care and treatment.

NAME: X SIGNED X
Date
X

ALL PATIENTS MUST COMPLETE THIS FORM

COVID-19 PANDEMIC DENTAL TREATMENT CONSENT FORM

I, _____X__ , consent to having dental treatment carried out during the COVID-19 pandemic.

I understand that the current COVID-19 pandemic brings a number of known and unknown risks.

I have chosen to seek dental treatment during the pandemic and feel that the treatment will help to maintain my oral health and avoid further deterioration and/or discomfort in the future.

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:
-High temperature or fever
-New, continuous cough
-Loss of, or change in, sense of smell or taste

I confirm that:
-I have not tested positive to COVID-19 in the last 7 days
-I am not waiting for the COVID-19 test or the results
-I do not live with someone who has either tested positive for COVID-19 or had symptoms for COVID- 19 in the last 14 days
- I have not been notified by NHS Test and Trace in the last 14 days that I am a contact of a person who has tested positive for COVID-19 and I do not live that person

Elite Dental Care would like to reassure you that we take your health and safety very seriously- we practise stringent infection control and sanitisation procedures before and after your dental treatment- which are designed to minimise infection risk to as low as humanly possible levels. These measures comply with guidance issued by Public Health England, who regulate the healthcare profession, and are updated on a regular basis. I understand that I have an elevated risk of contracting the virus simply by being in a dental surgery.

Signature: _____X_____ Date:_____X

ALL NHS PATIENTS MUST FILL OUT THIS FORM.

PR (01/04/2018 R7) **Practice Record Form - Patient Declaration** NHS

ONE FORM MUST BE COMPLETED FOR EACH COURSE OF TREATMENT

This form is to be retained in the Dental Practice unless requested by the NHSBSA or other authorised body

PATIENT INFORMATION (TO BE COMPLETED BY THE DENTAL PRACTICE)

Provider name, address and location number

SURNAME (in CAPITALS) X

FORENAME (in CAPITALS) X

Date of Birth D D M M Y Y Y Y X

ETD Claim Reference Number

Evidence of exemption or remission seen Yes ☐ No ☐

Date of acceptance Day D D Month M M Year Y Y

Date of Completion or last visit Day D D Month M M Year Y Y

THE REMAINDER OF THIS FORM MUST BE COMPLETED BY, OR ON BEHALF OF, THE PATIENT

PATIENT DECLARATION (TO BE COMPLETED FOR ALL PATIENTS)

I consent to the dental provider named above, or their representative, to examine me under the NHS and to give me any necessary care and treatment that I am willing to undergo within NHS arrangements. I agree to pay the statutory charges for the NHS dental service I receive, unless I have completed a valid claim for free or reduced cost NHS dental services below, and that I may have to pay the full amount prior to treatment. I agree, if necessary, to be examined and/or to have my dental records examined by the NHS Business Services Authority (NHSBSA) or other authorised bodies. I declare that the information I give on this form is correct and complete. I understand that if it is not, appropriate action may be taken against me.

Signature X Date X

If you are signing for the patient give details below:

Name (in CAPITALS)

Relationship to patient

To enable the NHS to prevent and detect fraud and mistakes, pay dentists and to secure the effective and efficient delivery of NHS and related services, relevant information on your NHS treatment may be shared with, and by the NHSBSA to NHS England, Department for Work and Pensions, HM Revenue & Customs, NHS Digital, NHS Counter Fraud Authority, NHS Service Commissioners and bodies performing functions on their behalf. Your personal data will be deleted within 10 years of receipt into our systems. Further details are available at **www.nhsbsa.nhs.uk/yourinformation**

What is your ethnic group?

Please choose **ONE** selection from this list to indicate your ethnic group:

- ☐ White British
- ☐ White Irish
- ☐ Other white background
- ☐ White & Black Caribbean
- ☐ White & Black African
- ☐ White & Asian
- ☐ Other mixed background
- ☐ Asian or Asian British Indian
- ☐ Asian or Asian British Pakistani
- ☐ Asian or Asian British Bangladeshi
- ☐ Other Asian background
- ☐ Black or Black British Caribbean
- ☐ Patient declined
- ☐ Black or Black British African
- ☐ Other Black background
- ☐ Chinese
- ☐ Any other ethnic group

Please provide your preferred method of contact below, as an alternative to your postal address

Email Address

Mobile Number

By providing this information, the NHSBSA may use this method to contact you to survey your NHS dentistry experience.

ONLY THOSE WHO DO NOT PAY FOR THEIR TREATMENT MUST COMPLETE THIS PART.

CLAIM FOR FREE OR REDUCED COST NHS DENTAL SERVICES

YOU MUST READ THIS FORM BEFORE YOU SIGN IT. ONLY SIGN IT IF IT IS CORRECT.

The patient is responsible for the accuracy of this claim, NOT the dental practice.

If you're not certain that you're entitled to receive free or reduced cost NHS dental services you MUST pay the dental practice. If you subsequently confirm that you were entitled to free or reduced cost dental services, you can claim a refund. If you have applied for a qualifying benefit or exemption certificate but have not received it yet, you must pay and claim a refund when/if you do receive it.

Checks on claims are undertaken to confirm you are entitled. Incorrect claims for free or reduced cost NHS dental services will result in a penalty charge of up to £100, in addition to the cost of NHS dental services.
You won't have the opportunity to pay for the services first to avoid the penalty charge.

a) I am entitled to free NHS dental services because on the first day of treatment:

- ☐ **I am under 18 years of age.**
- ☐ **I am 18 years of age and in full time education** — Enter Name of college or university
- X ☐ **I am pregnant** } NHS Maternity Exemption certificate/card no.
- ☐ **I had a baby in the last 12 months** } Date baby due/born D D M M Y Y
- ☐ **I am currently in prison or a young offenders institution**

b) I am entitled to free NHS dental services because during the course of treatment I get, or am included in an award (as a claimant, partner, or dependent person under 20) of:

- ☐ **Income Support (Incapacity benefit and Disability** Living Allowance does **NOT** count)
- X ☐ **Income-based Jobseeker's Allowance** (Contribution-based does **NOT** count)
- ☐ **Income-related Employment & Support Allowance** (Contribution-related does **NOT** count)
- ☐ **Pension Credit Guarantee Credit** (Savings Credit on its own does **NOT** count)
- ☐ **Universal Credit** (in the last assessment period there were no earnings, or earnings were within the allowed limit, please check at www.nhs.uk/healthcosts)

Please complete details below

Print name of person receiving benefit

Date of Birth D D M M Y Y Y Y

Enter National Insurance Number

DURING THE COURSE OF TREATMENT THESE ARE THE ONLY BENEFITS THAT ENTITLE YOU TO FREE NHS DENTAL SERVICES

c) I am entitled to free NHS dental services because I am named on one of the following certificates that is valid during the course of treatment:

- ☐ **HC2 Certificate** — Enter Certificate Number
- ☐ **NHS Tax Credit Exemption Certificate/Card** (or entitled to one) — Enter Certificate/card Number

(You are not automatically entitled because you receive Tax Credits; there are qualifying conditions, please check at www.nhs.uk/healthcosts. If you qualify you will be sent an exemption certificate/card, but if you don't have one you can use the award notice as proof.)

d) I am entitled to reduced cost NHS dental services because:

- ☐ **I am named on a HC3 certificate that is valid during the course of treatment which limits the amount I have to pay to** £ Enter Certificate Number

I confirm that the information I have given above is correct and complete and that I am entitled to free or reduced cost NHS dental services as above. **I understand that I will have to pay for my treatment and a penalty charge of up to £100, if it is not correct and I am not entitled.**

Signature X Date X

If you are signing for the patient give details below:

Name (in CAPITALS)

Relationship to patient

Elite Dental Care

ONLY COMPLETE IF RELEVANT TO YOUR TREAMTMENT.

DENTURE CONSENT FORM

There are many variables which may contribute to failure of dentures. General possibilities include:
(1) Gum tissues which cannot bear the pressures placed upon them resulting in excessive tenderness and sore spots, especially during healing following extraction and denture placement.
(2) Jaw ridges which may not provide adequate support and/or retention as shrinkage occurs following extractions.
(3) Musculature in the tongue, floor of the mouth, cheeks, etc, which may not adapt to and be able to accommodate the new artificial appliances.
(4) Excessive gagging reflexes as the mouth adapts to the new dentures.
(5) Excessive saliva or excessive dryness of mouth.
(6) General psychological and/ or physical problems interfering with success.

FAILURE OF REMOVABLE PARTIAL DENTURES

Many variables may contribute to unsuccessful utilizing of immediate partial dentures (removable bridges). The variables may include those problems related to failure of complete dentures, in addition to:
(1) Natural teeth to which partial dentures are anchored (called abutment teeth) may become tender, sore, and/or mobile as support of the ridge changes during healing.
(2) Abutment teeth may decay or erode around the clasps or attachments.
(3) Tissues supporting the abutment teeth may fail after healing is complete.

BREAKAGE

Due to the types of materials which are necessary in the construction of these appliances, breakage may occur even though the materials used were not defective. Factors which may contribute to breakage are:
(1) Chewing on foods or objects which are excessively hard.
(2) Gum tissue shrinkage which causes excessive pressures to be exerted unevenly on the dentures, especially as the tissues heal and change.
(3) Cracks which may be unnoticeable and which occurred previously from causes such as those mentioned in (1) , (2) and (4) use of porcelain teeth as part of the denture, or the dentures having been dropped or damaged previously in the event the dentures are relined. The above factors listed may also cause extensive denture tooth wear or chipping.

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LOOSE DENTURES

Immediate complete dentures normally become less secure over the initial months as healing progresses and the ridge changes. Dentures themselves do not change unless subjected to extreme heat or dryness. After several months once healing is complete, the dentures will generally be quite loose and a reline or even rebase (replacement of all tissue coloured material supporting the teeth) will become necessary. During the healing process some chair side relines may be performed, but eventually a laboratory processed reline or rebase will be necessary. It will be necessary to charge a fee for relining or rebasing dentures and I understand that the fee for immediate dentures does not cover this reline or rebase fee. Immediate partial dentures may become loose for the same reasons listed.

ALLERGIES TO DENTURE MATERIALS
Infrequently, the oral tissues may exhibit allergic symptoms to the materials used in construction of either partial dentures or full dentures.

FAILURE OF SUPPORTING TEETH AND/OR SOFT TISSUES.
Natural teeth supporting immediate partial dentures may fail due to decay; excessive trauma; gum tissue or bony tissue problems. This may necessitate extraction. The supporting soft tissues may fail due to many problems including poor dental or general health. Even though the utmost care and diligence is exercised in preparation for and fabrication of immediate prosthetic appliances, there is the possibility of failure with patients not adapting to the new dentures.

I understand that the process of fabricating and fitting removable prosthetic appliances Partial dentures and/or complete artificial dentures, includes risks and possible failures.

Patient(print name) _____ X

Patient (Signature) _____ X

Date_____ X

ONLY COMPLETE IF RELEVANT TO YOUR TREAMTMENT.

Consent for periodontal treatment

Periodontal treatment is a dental procedure during which the teeth are cleaned above and below the gums. The intended benefits of the procedure includes the elimination of active periodontal disease (also called gum disease) aiming to prevent the loss of teeth.

As with all medical procedures there are risks and potential complication which you must be aware of before you can give your consent.

Expected complications.

- **Numbness lasting a few hours.**
- **Soreness of the gums lasting a few days.**
- **Requirement for maintenance cleaning in the future.**

Common risks and compilations.

- **Trauma to other parts of the mouth including teeth, gums, cheeks, tongue ect.**
- **Some teeth will have increased sensitivity for some time after the procedure.**
- **Inability to clean the tooth well enough to control periodontal disease.**
- **Cosmetic changes to the gums.**

Rare risks and complications

- **Trauma to tissues underneath the tooth including bone, sinus, nerves supplying other teeth etc.**
- **Allergic reaction to something used during the procedure.**

Periodontal treatment is not successful 100% of the time even if all parts of the procedure go as planned. Therefore some teeth that have undergone the procedure will require further treatment or might require extraction.

Alternative options.

1. **Referral to a specialist in this field ho may be able to treat the tooth better via the use of a microscope and specialist equipment etc.**
2. **Treating the tooth in a different way such as extraction.**
3. **Refusing treatment but this will result in a high risk of further loss of gum strength ultimately leading to loss of some teeth.**

By signing below I acknowledge that this procedure has been explained to me and I have had the time to ask questions, consider my options and am happy to proceed

Signature:_____ X Date_____ X

Elite Dental Care

ONLY COMPLETE IF RELEVANT TO YOUR TREAMTMENT.

CROWN AND BRIDGE CONSENT FORM

Dental crowns are restorations that cover or cap teeth, restoring them to their natural size, shape, and colour. A crown not only helps with appearance, but can strengthen a tooth as well. A fixed (non-removable) bridge is designed to replace teeth that have been lost.
Missing teeth may need to be replaced for appearance, or to prevent or correct bite and gum problems related to shifting or stressed teeth.
Dental crowns and bridges are made of porcelain, and may or may not have an inner layer of metal, while some are made of metal alone.
As with all procedures, there are certain potential problems associated with crowns and bridges. These include, but are not limited to:

- The potential need for root canal therapy: The need for root canal therapy may become apparent during a crown preparation, or after a crown is made.
- Dark lines at the gum line may appear on crowns or fixed bridges lined with metal. This is the metal edge of the crown. If the gum recedes after placement, this metal will show. Sometimes this can be corrected, other times a new crown or bridge might be recommended.
- Food impaction may occur under a bridge- this may be an unavoidable condition. Meticulous home care is required.

Crowns should usually be completed within one month. Failure to keep appointments (resulting in wearing the temporary crown for longer) can lead to gum disease, tooth loss, or a need to redo the crown at additional cost.

I further understand that I may be wearing temporary crowns for several weeks, which may come off and I must be careful to ensure that they are kept on until the permanent crowns are delivered.

I understand that sometimes it is not possible to match the colour of natural teeth exactly with artificial teeth.
I realise the final opportunity to make changes in my new crown (cap), or bridge, including shape, fit, size, and colour will be before permanent cementation. After permanently cementing crowns and/or bridges, NO changes can be made.
I understand that like natural teeth, crowns and bridges need to be kept clean with proper oral hygiene and periodic professional cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment and possible replacement of the crown(s) and/or bridge.
All replacements due to decay will be the patient's responsibility, however, any breakage, cracks and fractures in the crown or bridge will be replaced at no charge to the patient.

Signature:_____ X Date_____ X

ONLY COMPLETE IF RELEVANT TO YOUR TREAMTMENT.

Root canal treatment consent form

Please review the following consent form. You will be required to sign this form prior to the initiation of treatment. Your signature does not commit you to any treatment.
Occasionally, medication will be prescribed by Elite Dental Care. Medications prescribed for discomfort and/or sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. We advise that you do not operate a motor vehicle or any hazardous device while taking such medications. In addition, certain medications may cause allergic reactions, such as hives or
Intestinal discomfort.
If any of these problems occur, please call **0208 346 8717** immediately. It is the patient's responsibility to report any changes in his/her medical history to your dentist.

I understand the root canal therapy is a procedure that retains a tooth, which may otherwise require extraction. Although root canal therapy has a good success rate, results cannot be guaranteed. Occasionally, a tooth, which has had root canal therapy, may require retreatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown and/or post and core will be necessary to restore the tooth, and your dentist will perform these procedures.
During endodontic treatment, there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges,
Existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when the tooth may not be amenable to endodontic treatment at all.
Other treatment choices include no treatment, a waiting period for more definitive symptoms to develop, or tooth extraction.
Risks involved in those choices might include, but are not limited to, pain, infection, swelling, loss of teeth, and infection to other areas.

Note: All medical records will be kept strictly confidential.

Patient (Print Name) _____ **X**

Patient (Signature) _____ **X**

(If patient is under the age of 18, the signature of a parent or guardian is required.)

Date _____ **X**

Elite Dental Care

ONLY COMPLETE IF RELEVANT TO YOUR TREAMTMENT.

TOOTH REMOVAL CONSENT FORM

I understand that the extraction of a tooth (teeth) has been recommended by my dentist. I have had any alternative treatment (if any) explained to me, as well as the consequences of doing nothing about my dental conditions. I understand that non-treatment may result in, but not be limited to: infection, swelling, pain, periodontal disease, malocclusion (damage to the way the teeth hit together) and systemic disease/infection. I understand that there are risks associated with any dental, surgical, and anesthetic procedure. These include, but are not limited to:

Post-operative infection or inflammation

- Swelling, bruising, and pain
- Damage to adjacent teeth or fillings
- Drug reactions and side effects
- Bleeding requiring more treatment
- Possibility of a small fragment of root or bone being left in the jaw intentionally
- when its removal is not appropriate (such fragments may work their way partially out of the tissue and need to be removed later)
- Delayed healing (dry socket) necessitating several post-operative visits
- Damage to sinuses requiring additional treatment or surgical repair at a later date
- Fracture or dislocation of the jaw
- Damage to the nerves during tooth removal resulting in temporary, or possibly partial or permanent numbness or tingling of the lip, chin, tongue, or other areas.

By providing my signature, I certify that I understand the recommended treatment, the fee involved, the risks of such treatment, any alternatives and risks of these alternatives, including the consequences of doing nothing. I have had all of my questions answered, and have not been offered any guarantees.

Signature: _____X__ Date:_____ X