

Please complete this form if you are a registered patient of our Dental Practice.

DATE:

FULL NAME:

DOB:

ADDRESS:

POST CODE:

EMAIL ADDRESS:

TELEPHONE NUMBER:

DENTIST REGISTERED WITH:

DATE OF LAST DENTAL VISIT:

Covid 19 Questionnaire for the past 14 days.

1. Have you or anyone in your household/support bubble tested positive for Covid 19?
2. Have you or anyone in your household/support bubble been notified by NHS test and Trace?
3. Have you or anyone in your household/support bubble been asked to self-isolate?
4. Have you or anyone in your household/support bubble travelled out of your region or flown back into the UK?
5. If you have flown back into the UK, have you been required to self-isolate?

DENTAL EMERGENCY:

AREA/TOOTH/SIDE WHERE YOU HAVE THE PROBLEM (ie Left/Right, upper/Lower):

WHEN/HOW DID THE PROBLEM OCCUR?

IS THERE ANY SWELLING?

CAN YOU TOUCH THE TOOTH?

CAN YOU EAT?

CAN YOU SLEEP?

ARE YOU CURRENTLY TAKING ANY MEDICATION?

ARE YOU ALLERGIC TO ANY MEDICATION?

PLEASE USE THIS TO WRITE ANY OTHER INFORMATION YOU FEEL WE REQUIRE TO ASSIST WITH YOUR EMERGENCY?

THANK YOU, WE WILL BE IN TOUCH SOON.