



### New Practice Questionnaire

Burgess-Hyder will soon be opening a new Dental Practice in the area. In order for us to run an effective service, we would appreciate it if you could fill out this questionnaire, so we are able to tailor the service to your requirements

All information given is strictly confidential and will not be used for any other reason than stated above.

#### Personal Data

Are you:

Male   
Female

Age:

18-25  26-35  36-45  46-55  56-65  65+

#### Requirements

Do you have any requirements to enable you to access the practice? E.g. Wheelchair access, interpreter

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#### Routine Treatment

On average, how often do you normally attend the Dental Surgery:

6 monthly   
Yearly   
Every 2 years   
Only when you have a problem

Which types of treatment have you had in the past:

Examination only	<input type="checkbox"/>	Crowns	<input type="checkbox"/>
Scale and polish	<input type="checkbox"/>	Bridges	<input type="checkbox"/>
Fillings	<input type="checkbox"/>	Veneers	<input type="checkbox"/>
Extractions	<input type="checkbox"/>	Dentures	<input type="checkbox"/>
Root Filling	<input type="checkbox"/>		

Do you normally have treatment carried out under sedation? Yes/No

### Opening times

Please indicate which of the following appointment times would be most convenient to you:

- Early morning 8am - 10am
- Mid Morning 10am - 12pm
- Lunch time 12pm - 2pm
- Afternoon 2pm - 5pm
- Evening 5pm - 7pm
- Saturday 9am - 12pm
- No preference

Are there any other times you would like the practice to be open?

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### Emergency Appointments

When booking an emergency appointment would you prefer:

- Allocated appointment time
- Drop in clinic

Would you be willing to travel to another site for emergency treatment? Yes/No

Would you find telephone advice useful? Yes/No

### Specialist Services

Would you be interested in any of the following services:

- Smoking Cessation Clinic
- Oral Health Advice Clinics
- Hygienist Clinics
- Home visits

### Transport

What form of transport would you use to get to the practice:

- Car
- Public Transport
- Taxi
- On Foot

**Thank you for taking the time to complete the questionnaire.**

**Children's Treatment Questionnaire**

**Male/Female**

**Age Range:**

0-3	<input type="checkbox"/>
3-6	<input type="checkbox"/>
6-10	<input type="checkbox"/>
11-18	<input type="checkbox"/>

**Special Requirements**

Wheelchair Access  
Interpreter  
Sign Language  
Other.....

**Attendance Patterns**

6 monthly	<input type="checkbox"/>
Yearly	<input type="checkbox"/>
Every 2 years	<input type="checkbox"/>
Only when have a problem	<input type="checkbox"/>

**Age when First Attended**

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**Past Treatments**

Exam only	<input type="checkbox"/>	Crowns	<input type="checkbox"/>
Scale and polish	<input type="checkbox"/>	Bridges	<input type="checkbox"/>
Fillings	<input type="checkbox"/>	Veneers	<input type="checkbox"/>
Extractions	<input type="checkbox"/>	Orthodontic	<input type="checkbox"/>
Root fillings	<input type="checkbox"/>	Dentures	<input type="checkbox"/>

**Treatment under:**

Sedation	<b>yes/no</b>
G/A	<b>yes/no</b>
<b>Nervous Patient</b>	<b>yes/no</b>
<b>Adequate oral hygiene advice</b>	<b>yes/no</b>
<b>Adequate dietary advice</b>	<b>yes/no</b>