



# Patient Forms

A Sensei Product

## Getting Started Guide



**Your Guide to a  
Successful Transition**

**Patient Forms**

**Getting Started Guide**

# Notice

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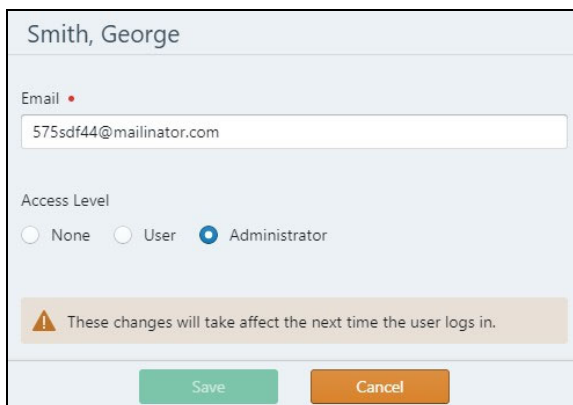
# 1 Using Patient Forms

Patient Forms is a cloud-hosted service that enables your patients to access and complete forms from any internet connection, using a tablet, computer, or mobile device. Forms can also be filled out by patients when they arrive at your office; for example, patients can acknowledge they have read the HIPAA Privacy form or they can fill out a Registration form.

## Setting Up User Accounts

When an on-premise DPMS site is created in Patient Forms, an account is created for the person accessing the site—the system administrator—but no password is provided. When the admin accesses the Patient Forms site for the first time, he or she must click **Forgot Password** and set the password.

Although all of the user accounts from the on-premise DPMS software are imported into Patient Forms as users, the access levels are set to **None**. The admin must access the **Users** window in each user account, add an email address, and set the required access level.

A screenshot of a web form titled "Smith, George". It contains an "Email" field with the text "575sdf44@mailinator.com". Below the email field is an "Access Level" section with three radio buttons: "None", "User", and "Administrator". The "Administrator" radio button is selected. At the bottom of the form, there is a yellow warning box with a triangle icon and the text "These changes will take affect the next time the user logs in." Below the warning box are two buttons: "Save" (green) and "Cancel" (orange).

The **Access Level** section contains the following settings:

- **None**—User receives the following message when trying to access Patient Forms: **You do not have access to this page. If you think you should have access, please contact your system administrator.**
- **User**—User can log in to Patient Forms, but cannot access **Administration > Settings and Administration > Users**. If he or she attempts to access this page, the following message is displayed: **You do not have access to this page. If you think you should have access, please contact your system administrator.**

**Note:** Users with **User** access-level might have to click **Forgot Password** and set her or his password.

- **Administrator**—User can log in to Patient Forms and access every window in Sensei Patient Forms.

## Accessing the Forms

To access the forms:

- In the United States—Log in to <https://patientforms.cs dental.com/> using your assigned user name and password.
- In the United Kingdom—Log in to <https://patientforms-emea.cs dental.com/> using your assigned user name and password.

From the **Patient Forms** website, you can access all forms and send a unique link to a patient so that she or he can fill out a form before arriving at your office. You can also direct patients to a button or a link to the forms on your website.

To view a form:

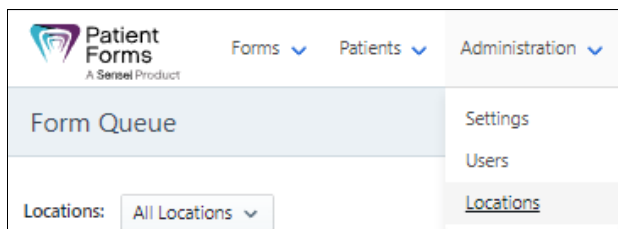
- 1 Select **Forms > Form Library**.
- 2 Select the form and click the **eye** icon on the right side of the window. The form is displayed.

## Setting Up the Location

If your practice has multiple locations with the same name, you can change the **Location** name that is displayed in Patient Forms.

To change the **Location** name to a **Display** name:

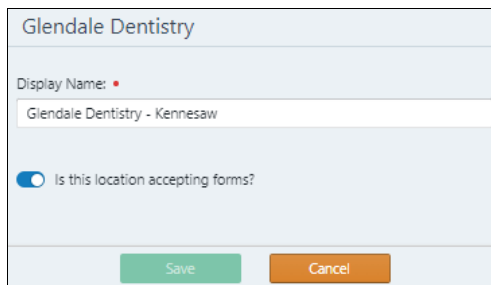
- 1 On the Patient Forms website, select **Administration > Locations**.



The **Location Settings** window is displayed.

Location Settings		
Business Name	Internal Name	Display Name
Exchange Dental	The Exchange Dental	Exchange Dental
Glendale Dentistry	Kennesaw	Glendale Dentistry - Kennesaw
Power Ranch Practice	Peachtree	Power Ranch Practice
Smiles r Us	Marietta	Smiles r Us
Smiley Dental Surgery	Smiley Dental Surgery	Smiley Dental Surgery
Total records: 5		

- 2 On the right side of the window, click the **Pencil** icon next to the name you want to change. The **Business Name** window is displayed.



The image shows a window titled "Glendale Dentistry". Inside, there is a "Display Name:" label with a red asterisk, followed by a text input field containing "Glendale Dentistry - Kennesaw". Below the input field is a toggle switch labeled "Is this location accepting forms?", which is currently turned on. At the bottom of the window are two buttons: "Save" (green) and "Cancel" (orange).

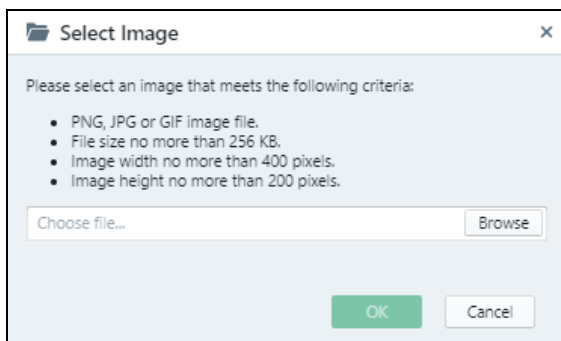
- 3 In the **Display Name** field, enter the name that you want to be displayed.
- 4 Click **Save**.

**Note:** If the location is not accepting forms, turn off the **Is this location accepting forms?** option and click **Save**.

## Uploading Your Logo

To display your logo on the forms:

- 1 On the Patient Forms website, select **Administration > Settings**. The **Settings** window is displayed.
- 2 Click **Change Image**. The **Select Image** window is displayed.



The image shows a window titled "Select Image" with a close button (X) in the top right corner. Inside, it says "Please select an image that meets the following criteria:" followed by a bulleted list: "PNG, JPG or GIF image file.", "File size no more than 256 KB.", "Image width no more than 400 pixels.", and "Image height no more than 200 pixels." Below the list is a text input field with the placeholder "Choose file..." and a "Browse" button to its right. At the bottom of the window are two buttons: "OK" (green) and "Cancel" (white).

- 3 Click **Browse**, select the logo image, and click **OK**.



## Using the Forms

To schedule an appointment, a patient must have a stub record in the practice management software, which includes at least the patient's name, phone number, and email address. Then the patient can provide additional information remotely or in your office.

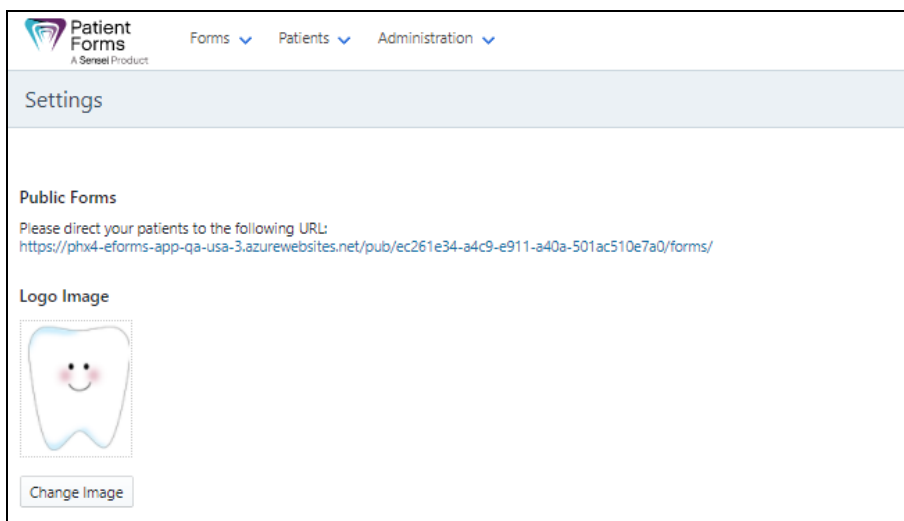
**Note:** The COVID forms can be found in the **Form Library**.

## Completing Forms Remotely

To provide the additional information your office needs, a patient can fill out an online Registration form from home or from the car; for example, if you have a virtual waiting room.

To send a link to a form to a patient:

- 1 Log in to the Patient Forms service, using your assigned credentials. The **Settings** window is displayed.



- 2 Copy the link, which is unique to your office, and paste it into an email or text message.
- 3 Send the message to the patient.

**OR**

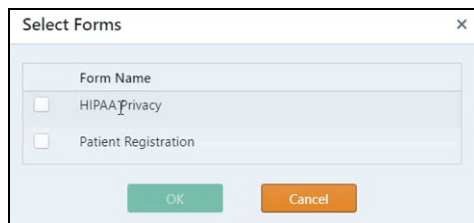
- 1 Send the URL for your office website to the patient.
- 2 Instruct the patient to click a button or a link you have added to the website to access the forms.

When the patient completes and saves a form, the form is displayed in the **Form Queue** for the office to review and accept or to put on-hold or reject. When you accept the form, the information, except for the medical history, is written automatically to the patient's record. You must manually enter the medical conditions and allergies.

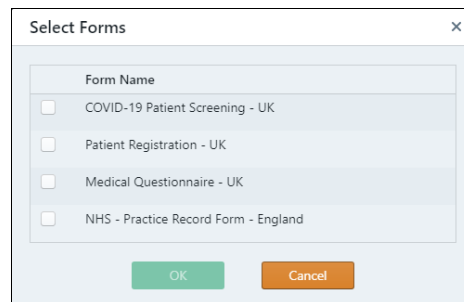
## Signing In and Completing Forms at the Office

To sign in and access the forms, a patient can use a tablet or computer in your office. To assign a form to a patient:

- 1 Log in to the Patient Forms service, using your assigned credentials. The **Settings** window is displayed.
- 2 Select **Patients > Appointments**.
- 3 Click the patient on the appointment schedule.
- 4 Click **Assign Forms**. The **Select Forms** window for the US or for the UK is displayed.

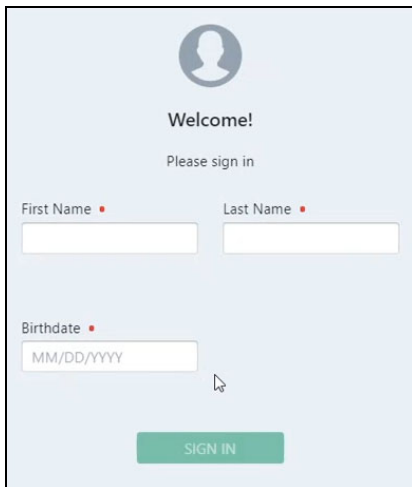


The 'Select Forms' window for the US displays a list of forms under the heading 'Form Name'. The list includes 'HIPAA Privacy' and 'Patient Registration', each with an unchecked checkbox. At the bottom, there are 'OK' and 'Cancel' buttons.

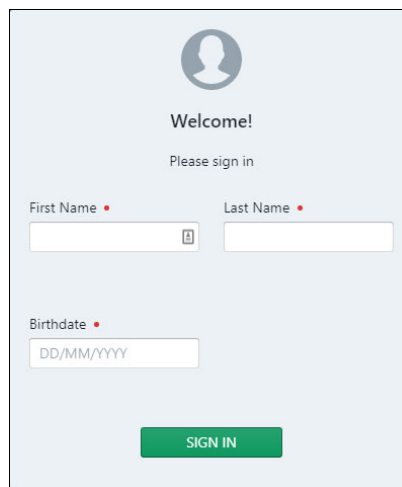


The 'Select Forms' window for the UK displays a list of forms under the heading 'Form Name'. The list includes 'COVID-19 Patient Screening - UK', 'Patient Registration - UK', 'Medical Questionnaire - UK', and 'NHS - Practice Record Form - England', each with an unchecked checkbox. At the bottom, there are 'OK' and 'Cancel' buttons.

- 5 Select the forms you want the patient to fill out or verify.
- 6 Click **OK**.
- 7 If the patient will be using a tablet, select **Patients > Patient Mode**.
- 8 Click **Start Patient Mode**. The **Welcome** window for the US or for the UK is displayed.



The 'Welcome!' window for the US features a user icon at the top, followed by the text 'Welcome!' and 'Please sign in'. Below this are input fields for 'First Name' and 'Last Name', each with a red asterisk. A 'Birthdate' field with a red asterisk and a placeholder 'MM/DD/YYYY' is also present. A green 'SIGN IN' button is at the bottom.



The 'Welcome!' window for the UK features a user icon at the top, followed by the text 'Welcome!' and 'Please sign in'. Below this are input fields for 'First Name' and 'Last Name', each with a red asterisk. A 'Birthdate' field with a red asterisk and a placeholder 'DD/MM/YYYY' is also present. A green 'SIGN IN' button is at the bottom.

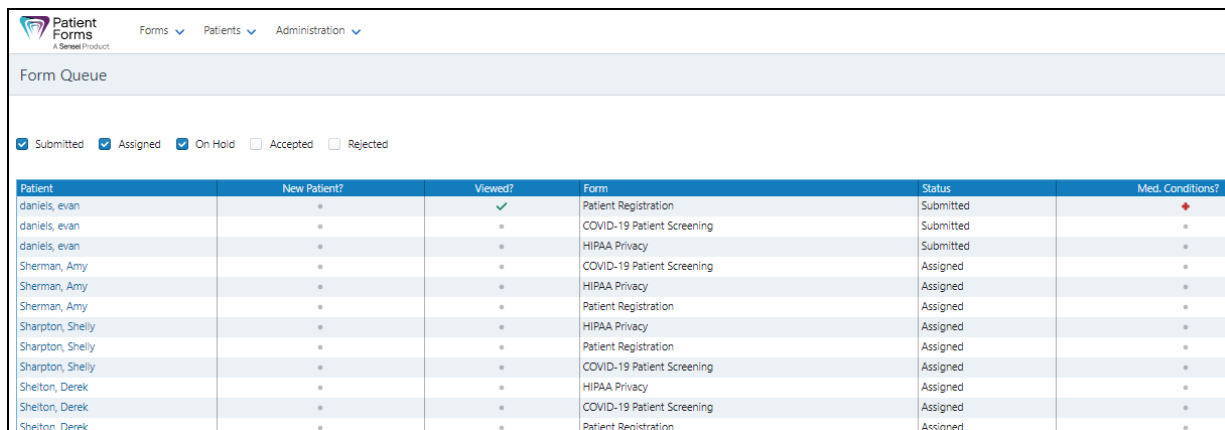
- 9 Hand the tablet to the patient and ask him to fill in the **Name** and **Birthdate** fields and click **SIGN IN**. A list of forms is displayed.
- 10 When the patient selects a form, she can fill out the form and sign it, or verify that the information populated from your software is correct.

When the patient completes and saves a form, the form is displayed in the **Form Queue** for the office to review and accept or to put on-hold or reject. When you accept the form, the information, except for the medical history, is written automatically to the patient's record. You must manually enter the medical conditions and allergies.

## Accessing a Saved Form

To access a form that has been saved by a patient:

- 1 In the **Patient Forms** window, select **Forms > Form Queue**. A list of patients who have filled out forms is displayed.



Patient	New Patient?	Viewed?	Form	Status	Med. Conditions?
daniels, evan	*	✓	Patient Registration	Submitted	✖
daniels, evan	*	*	COVID-19 Patient Screening	Submitted	*
daniels, evan	*	*	HIPAA Privacy	Submitted	*
Sherman, Amy	*	*	COVID-19 Patient Screening	Assigned	*
Sherman, Amy	*	*	HIPAA Privacy	Assigned	*
Sherman, Amy	*	*	Patient Registration	Assigned	*
Sharpton, Shelly	*	*	HIPAA Privacy	Assigned	*
Sharpton, Shelly	*	*	Patient Registration	Assigned	*
Sharpton, Shelly	*	*	COVID-19 Patient Screening	Assigned	*
Shelton, Derek	*	*	HIPAA Privacy	Assigned	*
Shelton, Derek	*	*	COVID-19 Patient Screening	Assigned	*
Shelton, Derek	*	*	Patient Registration	Assigned	*

**Tip:** To sort the information in the list, you can click any column, except the **Form** column.

- 2 To open a form that has been filled out remotely, select **Patients > Search** and type the patient's name in the **Search** field. To open a form that has been filled out in the office, select the patient and click the **eye** icon on the right side of the window.
- 3 If medical conditions are present, a **red cross** icon is displayed. Open the form to view the medical history.
- 4 Click one:
  - **Put On-Hold**—The form is returned to the tablet so that the patient can edit the information.  
**Note:** The **Put On-Hold** status is used only in the office.
  - **Reject**—The form is archived, but deleted from view without updating the practice management software.
  - **Accept**—The **Form Acceptance** window is displayed.

**Form Acceptance**

**Patient**

Evan Daniels  
DOB: 3/29/1967 (53y) ♂  
Home: (916) 555-3269  
Email: ev.daniels@demo.org

⚠ This form includes medical conditions and/or allergies.  
☐ I acknowledge that I've reviewed this information

**Primary Insurance**

☐ Use the following payer  
(Select One) Carestream Insurance

☐ Use the following plan  
(Select One) Carestream Dental Plan

☒ Create a new payer  
☒ Create a new plan

**Save** **Cancel**

- 5 If the patient has allergies or medical conditions, select **I acknowledge that I've reviewed this information**.
- 6 Review the insurance information and determine if you need to create a new payer and plan **OR** if you must assign existing ones.
- 7 To assign an existing insurance payer and plan, click **Use the following payer** and click the drop-down list. A list of insurance providers is displayed.

**Form Acceptance**

**Patient**

Evan Daniels  
DOB: 3/29/1967 (53y) ♂  
Home: (916) 555-3269  
Email: ev.daniels@demo.org

⚠ This form includes medical conditions and/or allergies.  
☐ I acknowledge that I've reviewed this information

**Primary Insurance**

☒ Use the following payer  
(Select One) Carestream Insurance

☐ Create a new payer  
☐ Create a new plan

**Save** **Cancel**

Select the payer from the list. Then click **Use the following plan** and select a plan.

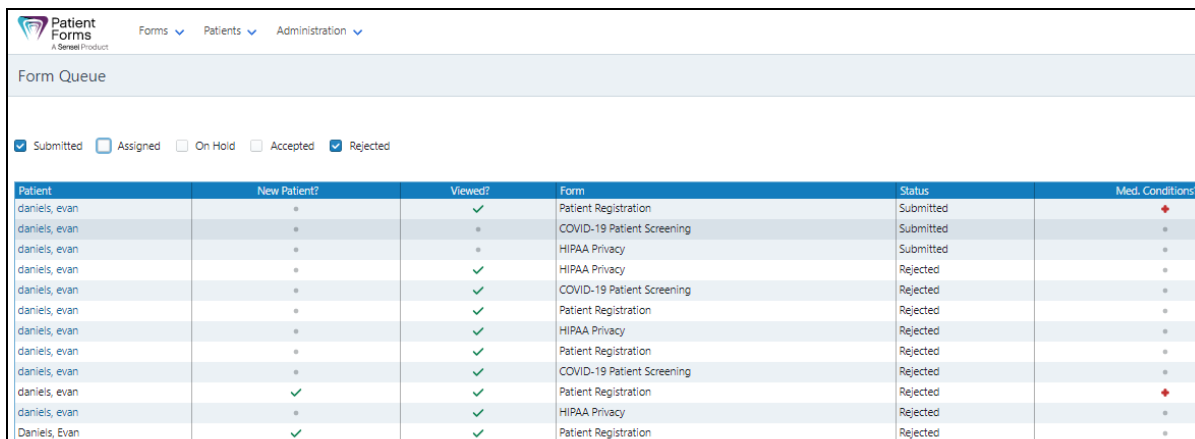
- 8 To create a new payer and plan, select **Use the following payer** to make sure the insurance payer and plan are not already in the database. If they are not, click **Create a new payer** and add the patient's payer and plan to the database.
- 9 Click **Save**. The information in the form is recorded in the patient's record.
- 10 To view the information in your software, access the appointment and click the patient's name. A snapshot of the patient's information is displayed.

- 11 In the snapshot, click **View Home**. The **Home** window is displayed.
- 12 Click **Patient Record**. The patient's information is displayed in the software.

## Rejecting Forms

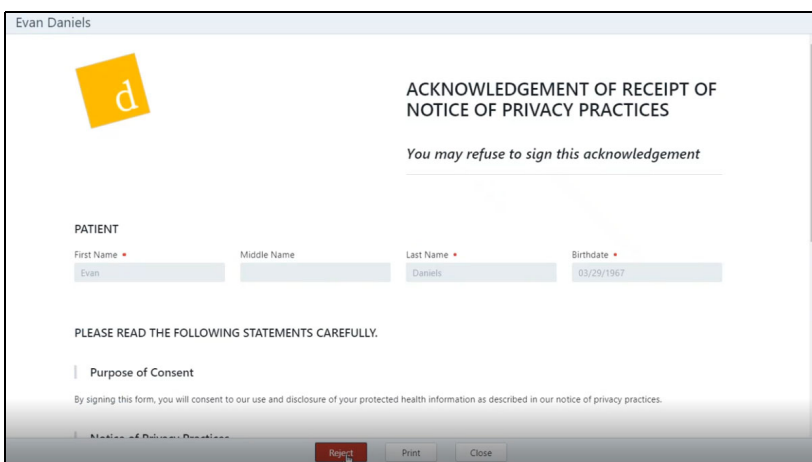
To reject a form:

- 1 On the Patient Forms website, select **Forms > Form Queue**. The **Form Queue** window is displayed.



Patient	New Patient?	Viewed?	Form	Status	Med. Conditions?
daniels, evan	*	✓	Patient Registration	Submitted	♦
daniels, evan	*	*	COVID-19 Patient Screening	Submitted	*
daniels, evan	*	*	HIPAA Privacy	Submitted	*
daniels, evan	*	✓	HIPAA Privacy	Rejected	*
daniels, evan	*	✓	COVID-19 Patient Screening	Rejected	*
daniels, evan	*	✓	Patient Registration	Rejected	*
daniels, evan	*	✓	HIPAA Privacy	Rejected	*
daniels, evan	*	✓	Patient Registration	Rejected	*
daniels, evan	*	✓	COVID-19 Patient Screening	Rejected	*
daniels, evan	✓	✓	Patient Registration	Rejected	♦
daniels, evan	*	✓	HIPAA Privacy	Rejected	*
Daniels, Evan	✓	✓	Patient Registration	Rejected	*

- 2 Click the patient's name whose form you want to reject. The form is displayed.



- 3 Click **Reject**. The form is archived, but it is deleted from view, and no information is written to the practice management software.

## Printing Forms

To print a form:

- 1 On the Patient Forms website, select **Forms > Form Queue**. The **Form Queue** window is displayed.
- 2 Click the patient's name whose form you want to print. The form is displayed.
- 3 Click **Print** and select the print options.
- 4 Click **Print** and **Close**.

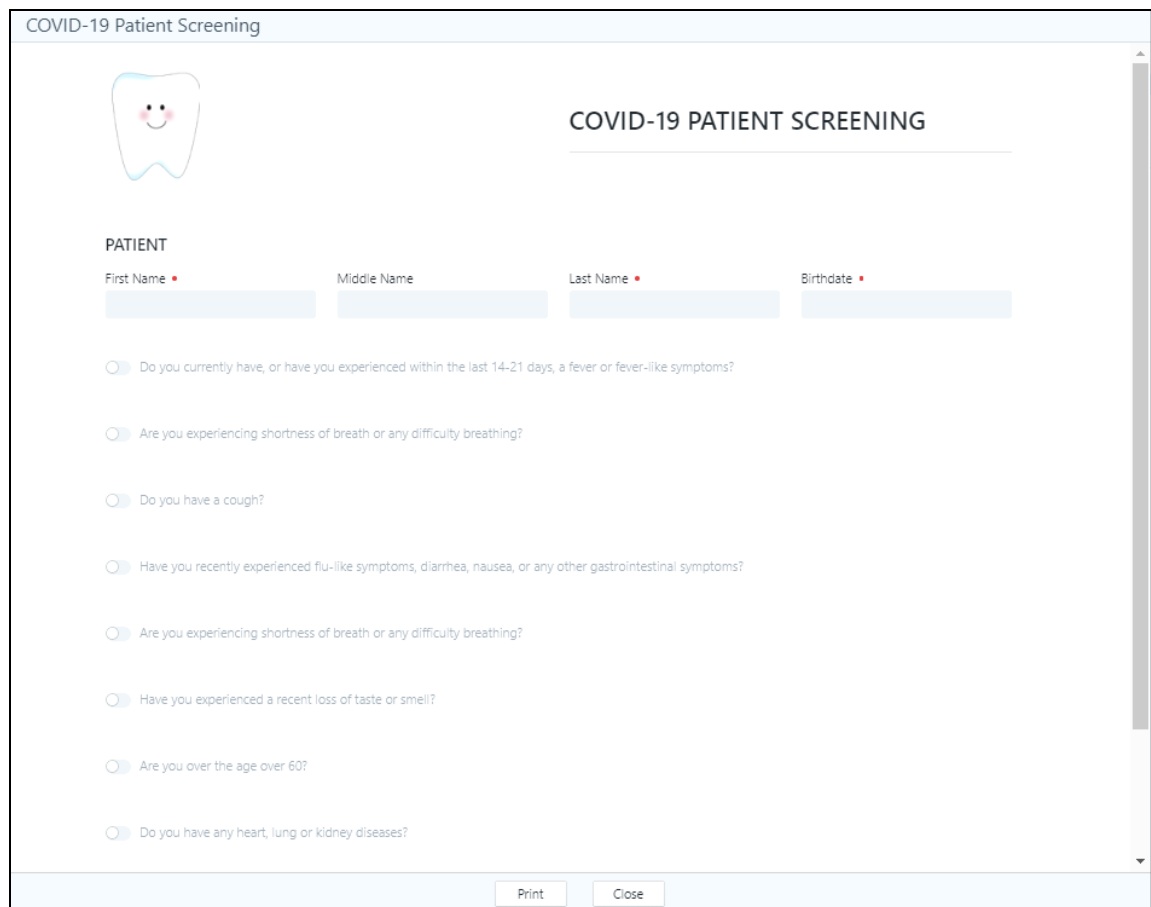
# 2 Forms Used in the United States

These Patient Forms are currently available in the United States:

- [COVID-19 Patient Screening Form](#)
- [HIPAA Privacy Form](#)
- [Patient Registration Form](#)
- [Additional Forms](#)

## COVID-19 Patient Screening Form

The following form is for COVID-19 screening:




The screenshot shows a web-based form titled "COVID-19 Patient Screening". At the top left is a cartoon tooth character with a smile. The form is divided into sections. The "PATIENT" section contains four input fields: "First Name", "Middle Name", "Last Name", and "Birthdate". Below this is a list of screening questions, each preceded by a radio button. The questions are: "Do you currently have, or have you experienced within the last 14-21 days, a fever or fever-like symptoms?", "Are you experiencing shortness of breath or any difficulty breathing?", "Do you have a cough?", "Have you recently experienced flu-like symptoms, diarrhea, nausea, or any other gastrointestinal symptoms?", "Are you experiencing shortness of breath or any difficulty breathing?", "Have you experienced a recent loss of taste or smell?", "Are you over the age over 60?", and "Do you have any heart, lung or kidney diseases?". At the bottom right of the form are two buttons: "Print" and "Close". A vertical scroll bar is visible on the right side of the form, indicating that there are more questions below the visible ones.

**Note:** To access more questions, use the scroll bar.

## HIPAA Privacy Form

The following HIPAA Privacy form must be filled out, reviewed, and signed by your patients:

HIPAA Privacy



ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement*

PATIENT

First Name \*

Middle Name

Last Name \*

Birthdate \*

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent

By signing this form, you will consent to our use and disclosure of your protected health information as described in our notice of privacy practices.

Notice of Privacy Practices

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting us.

ACKNOWLEDGEMENT

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Please Sign \*

If a guardian/representative signs this authorization on behalf of the patient, please complete the following section

Name of Guardian/Representative

Relationship to patient

Print

Close

## Patient Registration Form

The following sections make up the Patient Registration form:

- **Patient Information**
- **Emergency Contact**
- **Responsible Party**
- **Primary Insurance**
- **Secondary Insurance**
- **Allergies**
- **Medical Conditions**
- **Other Health Questions**
- **Miscellaneous**

## Patient Information

<b>Patient Information</b>				
Patient Details				
First Name ▾	Middle Name	Last Name ▾	Title	Nick Name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
SSN	Birthdate ▾	Gender ▾	Email Address	
<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text" value="Select..."/>	<input type="text"/>	
Home Address				
Address Line 1 ▾		Address Line 2		
<input type="text"/>		<input type="text"/>		
City ▾	State ▾		ZIP ▾	
<input type="text"/>	<input type="text" value="Select..."/>		<input type="text"/>	
Phone Number(s) <small>(At least one phone number is required)</small>				
Cell Phone	Home Phone	Work Phone	Ext.	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

## Emergency Contact

<b>Emergency Contact</b>			
Emergency Contact Details			
First Name ▾	Last Name ▾	Relationship ▾	
<input type="text"/>	<input type="text"/>	<input type="text" value="Select..."/>	
Phone Number(s) <small>(At least one phone number is required)</small>			
Cell Phone	Home Phone	Work Phone	Ext.
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



## Responsible Party

<b>Responsible Party</b>				
Responsible Party Details				
First Name *	Middle Name	Last Name *	Title	Nick Name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
SSN	Birthdate	Gender	Relationship *	
<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text" value="Select..."/>	<input type="text" value="Select..."/>	
Address				
Address Line 1		Address Line 2		
<input type="text"/>		<input type="text"/>		
City	State	ZIP		
<input type="text"/>	<input type="text" value="Select..."/>	<input type="text"/>		
Phone Number(s) <small>(At least one phone number is required)</small>				
Cell Phone	Home Phone	Work Phone	Ext.	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

## Primary Insurance

The payer and plan information is matched to the existing providers in the software database. You can assign the patient to one of the existing plans or create a new one. See steps 7 and 8 on [page 7](#).

<b>Primary Insurance</b>		
<b>Policy Holder</b>		
First Name	Middle Name	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Member ID	Birthdate	Patient's Relationship to Policy Holder
<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text" value="Select..."/>
<b>Plan/Policy</b>		
Insurance Company	Plan Name	Group Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address Line 1		Address Line 2
<input type="text"/>		<input type="text"/>
City	State	ZIP
<input type="text"/>	<input type="text" value="Select..."/>	<input type="text"/>

## Secondary Insurance

<b>Secondary Insurance</b>		
<b>Policy Holder</b>		
First Name	Middle Name	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Member ID	Birthdate	Patient's Relationship to Policy Holder
<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="text" value="Select..."/>
<b>Plan/Policy</b>		
Insurance Company	Plan Name	Group Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address Line 1		Address Line 2
<input type="text"/>		<input type="text"/>
City	State	ZIP
<input type="text"/>	<input type="text" value="Select..."/>	<input type="text"/>

## Medical Health History

A patient's medical health history includes:

- Allergies
- Medical conditions
- Other health questions

Patients indicate their medical health histories, such as allergies and conditions, by using a toggle button. After the form is saved, you must update the medical health history information in the patient's record in your practice management software.

### Allergies

#### Medical Health History

##### Allergies

Are you allergic to or have you had reaction to:

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine or other narcotics	<input type="checkbox"/> Local anesthetics	<input type="checkbox"/> General anesthetics
<input type="checkbox"/> Penicillin or other antibiotics	<input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Latex	<input type="checkbox"/> Barbituates, sedatives, sleeping pills
<input type="checkbox"/> Certain foods	<input type="checkbox"/> Hay fever/seasonal	<input type="checkbox"/> Animals	<input type="checkbox"/> Iodine
<input type="checkbox"/> Metals			

Other

Please list any other allergies not indicated above

## Medical Conditions

### Medical Conditions

Do you have, or have you had any of the following?

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Alcohol abuse        | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Angina                  |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Artificial heart     | <input type="checkbox"/> Artificial joints    | <input type="checkbox"/> Asthma                  |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Cancer/chemotherapy  | <input type="checkbox"/> Colitis              | <input type="checkbox"/> Congenital heart defect |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Drug abuse           | <input type="checkbox"/> Emphysema               |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Fainting spells      | <input type="checkbox"/> Fever blisters       | <input type="checkbox"/> Frequent headaches      |
| <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> HIV or AIDS          | <input type="checkbox"/> Heart attack         | <input type="checkbox"/> Heart surgery           |
| <input type="checkbox"/> Hemophilia        | <input type="checkbox"/> Hepatitis A or B     | <input type="checkbox"/> Hepatitis C          | <input type="checkbox"/> High blood pressure     |
| <input type="checkbox"/> Kidney problems   | <input type="checkbox"/> Liver disease        | <input type="checkbox"/> Low blood pressure   | <input type="checkbox"/> Mitral valve            |
| <input type="checkbox"/> Pace maker        | <input type="checkbox"/> Pneumocystis         | <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Radiation therapy       |
| <input type="checkbox"/> Rheumatic fever   | <input type="checkbox"/> Shingles             | <input type="checkbox"/> Sickle cell disease  | <input type="checkbox"/> Sinus problems          |
| <input type="checkbox"/> Stroke            | <input type="checkbox"/> Thyroid problems     | <input type="checkbox"/> Organ transplant     | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Ulcers            | <input type="checkbox"/> Venereal disease     | <input type="checkbox"/> Yellow jaundice      |  |

Other

Please list any other medical conditions not indicated above

## Other Health Questions

**Other Health**

☐ Do you use tobacco?

☐ Do you use controlled substances (drugs)?

☐ Are you required to premedicate before any dental treatment?

**WOMEN ONLY:**

☐ Are you pregnant?

Number of weeks

☐ Are you nursing?

Medications currently taking

Is there any other health item we should be aware of (Medical Alert)?

## Miscellaneous

**Misc.**

How did you hear about our office?

## Additional Forms

In addition, you have access to the following forms:

- Alveoloplasty Sequestrectomy Informed Consent
- Alveoloplasty Sequestrectomy Informed Consent (Spanish)
- Anesthesia Informed Consent
- Anesthesia Informed Consent (Spanish)
- Biopsy Consent
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- Coronectomy Informed Consent (Spanish)
- Dental Implant Informed Consent
- Dental Implant Informed Consent (Spanish)
- Dental Implant with Grafting Informed Consent
- Dental Implant with Grafting Informed Consent (Spanish)
- Distant Site Graft Harvest Informed Consent
- Distant Site Graft Harvest Informed Consent (Spanish)
- Distraction Osteogenesis Surgery Informed Consent

- Distraction Osteogenesis Surgery Informed Consent (Spanish)
- Facial Reconstruction and Fracture Repair
- Facial Reconstruction and Fracture Repair (Spanish)
- Frenectomy Informed Consent
- Frenectomy Informed Consent (Spanish)
- Incision and Drainage Informed Consent
- Incision and Drainage Informed Consent (Spanish)
- Informed Consent Template
- Informed Consent Template (Spanish)
- Jaw Joint Arthrocentesis Arthroscopic Surgery Informed Consent
- Jaw Joint Arthrocentesis Arthroscopic Surgery Informed Consent (Spanish)
- Jaw Joint Surgery Informed Consent
- Jaw Joint Surgery Informed Consent (Spanish)
- Laser-Assisted Uvulopalatoplasty (LAUP) Informed Consent
- Laser-Assisted Uvulopalatoplasty (LAUP) Informed Consent (Spanish)
- Nerve Lateralization Informed Consent
- Nerve Lateralization Informed Consent (Spanish)
- Nerve Repair Surgery Informed Consent (Spanish)
- Nerve Repair Surgery Informed Consent
- Orthognathic Surgery Informed Consent
- Orthognathic Surgery Informed Consent (Spanish)
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- Osteogenic Orthodontics Informed Consent (Spanish)
- Osteomyelitis Treatment Informed Consent
- Osteomyelitis Treatment Informed Consent (Spanish)
- Placement of Temporary Anchorage Device Informed Consent
- Placement of Temporary Anchorage Device Informed Consent (Spanish)
- Salivary Duct Stone Removal Informed Consent
- Salivary Duct Stone Removal Informed Consent (Spanish)
- Salivary Gland Removal Informed Consent
- Salivary Gland Removal Informed Consent (Spanish)
- Sinus Surgery Informed Consent
- Sinus Surgery Informed Consent (Spanish)
- Soft and/or Hard Tissue Grafting Informed Consent (Spanish)
- Soft and/or Hard Tissue Grafting Informed Consent
- Surgical Exposure and/or Bracketing of Impacted Teeth Informed Consent
- Surgical Exposure and/or Bracketing of Impacted Teeth Informed Consent (Spanish)
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- Surgical Tooth Repositioning Informed Consent
- Tooth Extraction Informed Consent
- Tooth Extraction Informed Consent (Spanish)
- Tooth Extraction with Grafting Informed Consent
- Tooth Extraction with Grafting Informed Consent (Spanish)
- Tracheostomy Informed Consent

- Tracheostomy Informed Consent (Spanish)
- Treatment of Cysts or Tumors Informed Consent
- Treatment of Cysts or Tumors Informed Consent (Spanish)

# 3 Forms Used in the United Kingdom

These Patient Forms are currently available in the UK:

- [COVID-19 Patient Screening Form – UK](#)
- [NHS – Practice Record Form – England](#)
- [NHS – Practice Record Forms – Scotland](#)
- [NHS – Practice Record Form – Wales](#)
- [Patient Registration Form – UK](#)
- [Medical Questionnaire – UK](#)
- [Additional Forms](#)

**Note:** To access more fields in each form, use the scroll bar.

## COVID-19 Patient Screening Form – UK

The COVID-19 Patient Screening form must be filled out by patients in the UK.

The screenshot shows a web browser window titled "COVID-19 Patient Screening - UK". Inside the window, the form has a title "COVID-19 Patient Screening - UK" at the top. Below the title, there is a section labeled "PATIENT" with three input fields: "First Name", "Last Name", and "Birthdate". Each field has a red asterisk indicating it is required. Below these fields are five questions, each with a radio button and a label: "Do you currently have, or have you experienced within the last 14-21 days, a fever or fever-like symptoms?", "Are you experiencing shortness of breath or any difficulty breathing?", "Do you have a cough?", "Have you recently experienced flu-like symptoms, diarrhoea, nausea, or any other gastrointestinal symptoms?", and "Have you experienced a recent loss of taste or smell?". At the bottom of the form, there are two buttons: "Print" and "Close".



## NHS – Practice Record Form – England

The NHS Patient Declaration form must be filled out, reviewed, and signed by NHS patients in England.

NHS - Practice Record Form - England

### Practice Record Form - Patient Declaration

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

Provider name, address and location number •

---

Surname •

Forename •

Date Of Birth •

Evidence of exemption or remission seen.

☐ Yes ☐ No

Date of acceptance

Date of completion or last visit


Print

Close

## NHS – Practice Record Forms – Scotland

The NHS Patient Declaration Acceptance and NHS Patient Declaration Completion forms must be filled out, reviewed, and signed by NHS patients in Scotland.

NHS - Practice Record Form - Patient Declaration Acceptance - Scotland



### NHS GENERAL DENTAL SERVICES PRACTICE RECORD FORM GP17PR

#### Patient Information

Surname •

Forename •

Date Of Birth •

Provider name, address and location number •


---

This form is to be retained in the dental practice and must be produced on request to the Scottish Dental Practice Board or any authorised officer of the Agency.

Print

Close

NHS - Practice Record Form - Patient Declaration Completion - Scotland



## NHS GENERAL DENTAL SERVICES PRACTICE RECORD FORM GP17PR

### Patient Information

Surname •

Forename •

Date Of Birth •

Provider name, address and location number •

This form is to be retained in the dental practice and must be produced on request to the Scottish Dental Practice Board or any authorised officer of the Agency.

## NHS – Practice Record Form – Wales

The NHS Patient Declaration form must be filled out, reviewed, and signed by NHS patients in Wales.

NHS - Practice Record Form - Wales

## Practice Record Form - Patient Declaration

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

Provider name, address and location number •

Surname •

Forename •

Date Of Birth •

Evidence of exemption or remission seen. ☐ Yes ☐ No

Date of acceptance

Date of completion or last visit

## Patient Registration Form – UK

The Patient Registration form must be filled out by patients in the UK.

Patient Registration - UK

Patient Registration - UK

Please fill in the following form to the best of your ability. The contents of this form are private and will be maintained as described in the data protection Consent form.

Patient Details

First Name •

Last Name •

Title

---

▼

Birthdate •

Gender •

---

▼

Email Address

Home Address

Address Line 1 •

Address Line 2

Print

Close

## Medical Questionnaire – UK

The Medical Questionnaire must be filled out by patients in the UK.

Medical Questionnaire - UK

Medical Questionnaire

Please fill in the following form to the best of your ability. The contents of this form are private and will be maintained as described in the data protection Consent form.

Forename •

Surname •

Birthdate •

Medical History

Are you currently receiving treatment from a doctor, hospital or clinic?

Yes

No

Are you currently taking any prescribed medicines?

Yes

No

Do you suffer from allergies to any medicines (e.g. penicillin), substances (e.g. latex, rubber) or foods?

Yes

No

Do you suffer from bronchitis, asthma or other chest conditions?

Yes

No

Do you suffer from fainting attacks, giddiness, blackouts or epilepsy?

Yes

No

Do you suffer from heart problems, angina, blood pressure problems, or strokes?

Yes

No

Print

Close

**Important:** The patient information from this form is automatically displayed in the R4 and Sensei Cloud software.

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