The Dental Law Partnership
Clinical Assessment Questionnaire

Our reference:-

Alternatively you could complete this and send this questionnaire online at www.dentallaw.co.uk by completing the "online claim check" and quoting the reference number case.key.

Please complete all the sections as fully as possible as this will help us to be able to assess your case quickly and accurately. If you do not have enough space in any of the sections then please continue on a blank piece of paper and firmly attach this to the questionnaire.

Please provide copies of any relevant documents or correspondence you have together with the questionnaire. Do not send any original documents at this time.

If you are able to provide any original or copy x-rays then please separately post these by special delivery clearly marked with your name and address attached to the x-ray.

Please note that following our assessment, whatever our advice, we will confidentially retain this questionnaire and copy documents for our records. Finally, please remember to sign and date the questionnaire on the last page

PERSONAL DETAILS

Title (Mr, Mrs etc)			
First Name(s)			
Family name			
Address			
Postcode			
Telephone (Home)			
Telephone (Mobile)			
Telephone (Work)			
Fax			
E-mail Address			
As a means of communication are you:			
Amenable to receiving text messages?	Yes / No		
Amenable to receiving emails?	Yes / No		
When would it be convenient to contact you by telephone:	Before 9:00am	Yes	No
	Between 9:00am & 5pm	Yes	No
	After 5:00pm	Yes	No
Date of Birth		Occupation	
National Insurance Number			

Dentists Doctors and Hospitals

Please note that we will not, under any circumstances, contact any of these dentists, doctors or hospitals without your authority. Please list the dentists, doctors and hospitals you have received relevant dental treatment from.

Approx Dates	Name and address of Dentist, Doctor, Hospital etc

Your Treatment
Please give details of the dental treatment you are complaining about.

Please tick the appropriate box in respect of the treatment you are complaining about.

NHS: ☐ Private: ☐

Please list the dentist(s) whose treatment you are complaining about.

Why do you think your treatment was sub-standard?

On what date was the treatment in question provided?
(please provide at least the approximate month and year)

Have you received a refund from your dentist in connection with this treatment? No ☐ Yes ☐

Have you instructed other solicitors in connection with this treatment? No ☐ Yes ☐

Are you involved in court proceedings in connection with this treatment? No ☐ Yes ☐

When did you first realise there was a problem with the treatment?

Please briefly set out how you found out, or were informed, that there was a problem with your dental treatment.

Your injury or damage. Please briefly set out how you have suffered as a result of the problems with the dental treatment in question.

Further treatment costs. Please give details of any corrective dental treatment you have had or will require in the future. Include details of the likely cost and also include an estimate of how long the treatment will take.

Any further relevant information. Please provide details in this space provided

How did you find out about the Dental Law Partnership?

Internet ☐

Please indicate the search engine used

google ☐ msn ☐ altravista ☐ other ……..
please give details

www.askthedentist.info	☐	**Solicitor**	☐
Dentist	☐	**Citizen Advice Bureau**	☐
GDC	☐	**Personal referral**	☐

Other ☐ Please give details ……

Your declaration and signature.

I confirm that the information contained within this questionnaire is true to the best of my knowledge and belief.

Signed……..

Name ……

Date…….