Today's advances in dental techniques and materials means that we are now more than ever, able to help you achieve the smile you've always wanted.

		Yes	No
1	Are you satisfied with the appearance of your teeth?		
2	Are you self-conscious about your teeth when you smile?		
3	Do you wish your teeth were whiter?		
4	Do you wish your teeth were shaped differently?		
5	Do you have sensitive teeth?		
6	Do you have missing teeth or gaps that need filling?		
7	Do you have any irregularly positioned teeth which you dislike?		
8	Do you have any discoloured teeth which embarrass you?		
9	Do your front teeth have fillings which do not match the colour of your teeth?		
10	Do you wish the fillings in your back teeth were tooth coloured?		
11	Do your gums appear red and swollen and bleed when you brush them?		
12	Do you suffer from bad breath – halitosis?		

13 If you could alter your smile what would you most like to change?

_____

_____

14 On a scale of 1-10 how happy are you with your smile?

1 2 3 4 5 6 7 8 9 10

Which of the following statements best describes your feelings about visiting the dentist? Tick the one you agree with.

- ☐ I feel relaxed
- ☐ I feel a little anxious
- ☐ I feel very anxious and nervous

Are there any dental procedures which have frightened you in the past, or which you are very anxious about?

_____

_____

MEDICAL HISTORY UPDATE

Please check that the health information on this form is still correct (including information on smoking & drinking). If not, amend as necessary or note any changes below.

DATE	LIST ANY CHANGES	PATIENT INITIALS	DENTIST INITIALS

CONFIDENTIAL MEDICAL HISTORY

Please provide us with information about your personal details and general health to help us treat you safely.

Do not answer any questions you do not understand, you will have the opportunity to discuss any queries with your dentist who will be happy to answer any of your questions. All information will be kept strictly confidential by the people caring for you.

Surname

First name

Title

Sex ☐ Male ☐ Female

DOB Day Month Year

Address

Post Code

Tel (Home)

Tel (Work)

Mobile No

Email

Occupation

Doctor's Name & Address

Doctor's Tel

DENTAL & IMPLANT CENTRE

We hope you will be very satisfied with the care you receive here. We would like to know what made you choose us.

- ☐ Convenient location
- ☐ I was recommended by a friend
- ☐ Convenient surgery hours
- ☐ Family member already a patient
- ☐ For emergency treatment only
- ☐ Referred by another dentist
- ☐ Internet search (Google, Bing, etc)
- ☐ Newspaper
- ☐ Website
- ☐ Previous patient
- ☐ Another reason, please specify below:

When did you last visit a dentist?

Have you left another dentist in order to come here?

☐ Yes ☐ No

If you think it is important to explain why, please do so:

Opt patients in or out of communications from the practice

- ☐ ☐ Product & Service Information or Promotion
- ☐ ☐ Newsletters
- ☐ ☐ Important Notifications

ARE YOU CURRENTLY

	Yes	No	GIVE DETAILS
Pregnant?			
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medicines (eg tablets, ointments, injections or inhalers, eye-drops, suppositories, nebulisers, the contraceptive pill or HRT)?			
Carrying a medical warning card?			

DO YOU SUFFER FROM

	Yes	No	GIVE DETAILS
Allergies to any medicines (eg penicillin), substances, (eg latex/rubber) or foods?			
Hay fever or eczema?			
Bronchitis, asthma or other chest condition?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Muscle problems (myopathy, dystrophy, paralysis)			
Heart problems, angina, blood pressure problems or stroke?			
Diabetes (or does anyone in your family)?			
Muscle problems Neurological (nerve) diseases ('neuropathies', MS etc)			
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases (including HIV, hepatitis, TB)?			
Stomach ulcers/hiatus hernia/indigestion?			

DID YOU, AS A CHILD OR SINCE, HAVE

	Yes	No	GIVE DETAILS
Rheumatic fever, heart murmur or chorea?			
Liver disease (eg jaundice, hepatitis)?			
Kidney disease?			
Any other serious illness?			

DID YOU, AS A CHILD OR SINCE, HAVE

	Yes	No	GIVE DETAILS
Blood refused by the Blood Transfusion Service?			
A bad reaction to general or local anaesthetic?			
A joint replacement or other implant?			
Treatment that required you to be in hospital?			
Heart surgery?			
Brain surgery?			
Growth hormone treatment before the mid-1980s?			
A close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt-Jakob Disease (CJD)			
Steroid treatment?			

DRINKING

How many units of alcohol do you drink per week?
(A unit is a half pint of lager, a single measure of spirits or a single glass of wine/aperitif) ____ units per week

SMOKING

	Yes	No	In Past	times per day
Do you smoke any tobacco products now (or did in the past)?				

Please give any other details which your dentist might need to know about, such as self-prescribed medication (eg aspirin)

Completed by (please tick) Self Parent Guardian Dentist

Signature Date