

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.

1	Are you satisfied with the appearance of your teeth?	Yes	No	12	Do you suffer from bad breath – halitosis?
2	Are you self-conscious about your teeth when you smile?			13	If you could alter your smile what would you most like to change?
3	Do you wish your teeth were whiter?				
4	Do you wish your teeth were shaped differently?			14	On a scale of 1-10 how happy are you with your smile?
5	Do you have sensitive teeth?				1 2 3 4 5 6 7 8 9 10
6	Do you have missing teeth or gaps that need filling?				Which of the following statements best
7	Do you have any irregularly positioned teeth which you dislike?				describes your feelings about visiting the dentist? Tick the one you agree with. I feel relaxed
8	Do you have any discoloured teeth which embarrass you?				I feel a little anxious
9	Do your front teeth have fillings which do not match the colour of your teeth?				I feel very anxious and nervous
10	Do you wish the fillings in your back teeth were tooth coloured?				Are there any dental procedures which have frightened you in the past, or which you are very anxious about?
11	Do your gums appear red and swollen and bleed when you brush them?				

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	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			



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 mem	ber already a patient						
	For emerger	ncy treatment only						
	Referred by	another dentist						
	Internet sear	rch (Google, Bing, etc)						
	Newspaper							
	Website							
	Previous patient							
	Another reas	son, please specify below:						
Whe	n did you last	visit a dentist?						
	you left anoth der to come h							
	Yes	No						

Opt patients in or out of communications from the practice

on

	\checkmark	火	Newsletters
--	--------------	---	-------------



If you think it is important to

explain why, please do so:







ARE YOU CURRENTLY						
	Yes	No				
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 FR	ОМ					
DO YOU SUFFER FR Allergies to any medicines (eg penicillin), substances, (eg latex/rubber) or foods?	OM Yes	No				
Allergies to any medicines (eg penicillin), substances,		No				
Allergies to any medicines (eg penicillin), substances, (eg latex/rubber) or foods?		No				
Allergies to any medicines (eg penicillin), substances, (eg latex/rubber) or foods? Hay fever or eczema? Bronchitis, asthma or		No				
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,		No				

Bruising or persistent bleeding following injury, tooth extraction or surgery?

pressure problems or stroke?

Neurological (nerve) diseases

Diabetes (or does anyone

('neuropathies', MS etc)

in your family)? Muscle problems

Arthritis?

Any infectious diseases (including HIV, hepatitis, TB)?

Stomach ulcers/hiatus hernia/indigestion?

DID YOU, AS A CHILD OR SINCE, HAVE

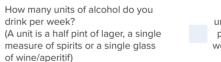
	Yes	No	GIVE DETAILS
Rheumatic fever,			
heart murmur or chorea?			
Liver disease			
(eg jaundice, hepatitis)?			
Kidney disease?			
Any other serious illness?			



DRINKING

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?



DID YOU, AS A CHILD OR SINCE, HAVE

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?

Yes No

GIVE DETAILS

units per week

SMOKING

Do you smoke any tobacco products now (or did in the past)?

times per Yes No Past day

Please give any other details which your dentist might need to know about self-prescribed medication (eg aspirin)								
	Completed	by (please tick)	Self	Parent	Guardia	an	Dentis	
	Signature				Date			



