



In order for us to provide you with the best care, please complete the following confidential questions:

Title: _____ Name: _____

Address: _____

Postcode: _____ Email: _____

Tel: _____ Mob: _____

Dental insurance: Yes No DOB: / /

Date of last dental examination: _____

How did you hear about us: _____

- Are you happy with your smile? Yes No
- Would you like your teeth to look whiter or brighter? Yes No
- Are your teeth sensitive? Yes No
- Have you any teeth you think are unsightly, misshapen or out of line? Yes No
- Are you concerned you may have bad breath or an unpleasant taste in your mouth? Yes No
- Do your gums bleed when you're brushing or flossing? Yes No
- Are you concerned about:
 - Old crowns that now do not match your other teeth or have dark lines at the gum?
 - Old or stained fillings that show when you smile?
 - Silver fillings that you would like replacing with tooth coloured restorations so that they blend in better?
 - Any missing teeth that you would like to replace?
- Do you suffer from headaches/neck aches or shoulder pain? Yes No
- Do you clench or grind your teeth? Yes No

Personal assessment

The Health Questions below are important to your dentist. Do not worry about questions you cannot answer, but feel free to discuss them further with your dentist.

Are you?

- 1) Receiving treatment from a doctor, hospital or clinic Yes No
- 2) Taking any pills, medicine or tablets Yes No
- 3) Allergic or have you reacted adversely to:
- a) Penicillin or any other drug or medicine Yes No
 - b) Latex or other materials Yes No
- 4) Taking any of the following:
- a) Antibiotics Yes No
 - b) Anticoagulants Yes No
 - c) Medicine for high blood pressure Yes No
 - d) Cortisone (steroids) Yes No
 - e) Insulin or other medication for diabetes Yes No
 - f) Other _____

In the past have you?

- 5) Had any serious illness or operations Yes No
- 6) Had any of the following diseases or problems:
- a) Rheumatic fever or rheumatic heart disease Yes No
 - b) Heart trouble, replacement heart valve, high blood pressure or stroke Yes No
 - c) Sinus trouble Yes No
 - d) Asthma Yes No
 - e) Diabetes Yes No
 - f) Hepatitis or HIV Yes No
- 7) Had abnormal bleeding associated with previous extractions, surgery or trauma Yes No
- 8) Had any problems with previous dental treatment Yes No
- 9) Do you smoke? Yes No
Number per day _____

Women only

- 10) Is there any possibility that you may be pregnant Yes No
Estimated date of delivery _____

Remarks: _____

Signature of patient: _____

Date: / /

Signature of dentist: _____

Thank you for taking the time to answer all our questions.