Welcome to our Practice

We are very pleased you have chosen our practice to provide your dental care. So that we can do our best for you, we would like to ask a few questions that will only take a few minutes to answer.

Patient Name ……..
Address ……
……
……
Postcode ……..

Telephone number (home) ……..
Telephone number (work) ……...
Telephone number (mobile) ……

Email address
……..

Date of birth Age .....

Doctor's Name:
.....

ARE YOU:

Please mark with a ☑ *tick if 'YES' and a* ☒ *if 'NO'*

❒ Attending or receiving treatment from a doctor?

❒ Taking any medication, pills, tablets, inhalers, ointments, injections etc? Please List
....
.....
.....

❒ Allergic to, or ever had any bad reaction to, any medicines e.g penicillin or substances e.g. latex allergy?

❒ Do you suffer from diabetes or epilepsy?

HAVE YOU:

❒ Had rheumatic heart fever, jaundice, kidney disease or hepatitis?

❒ Ever been told you have a heart murmur or heart problem?

❒ Had any blood pressure problems?

❒ Had a pacemaker fitted or have you had any form of heart surgery?

DO YOU:

❒ Suffer from hay fever, eczema or asthma?

❒ Carry a warning card?

❒ Think you may be pregnant?

❒ Smoke? If so, how many? ……..

Are you experiencing any pain or discomfort in your teeth, gums or jaws?

Do any of the following things bother you about the appearance of your teeth?

Colour? ……..

Metal fillings showing? ……..

Size/shape of teeth? …….

Crooked teeth or gaps? …….

Teeth becoming worn? …….

Is there anything that worries you about having dental treatment?

Completed by: Self/Parent/Guardian

Signature .....

Date .....

Thank you for answering our questions.

OFFICE USE ONLY	
Checked by	……
Date	……