

How do you feel about having dental treatment? *(Please, do not hesitate to tell us if you are nervous as this will help us tailor your treatment more efficiently)*

When did you last attend the dentist and what did you have done?

Do you visit the dentist regularly? Yes / No

Do you have any allergies to Latex, foods or any other substances? *If yes please specify.*

How would you describe your diet?

Do you smoke? If yes how many a day? Yes / No x

How many units of alcohol would you normally consume weekly?
..... units a week

Where did you hear about us?

Completed by: Self / Parent / Guardian (delete where applicable)

Signature:

Date:



New Patient Dental Form Welcome

Please note that all details entered on this form are and will remain confidential.

Personal details

Name:

Date of birth:

Address:

Home Tel:

Mobile:

E-mail:

Please tell us how you would prefer your reminders:

Telephone Mobile E-mail

Occupation:

GP's name:

GP's address:

Dental Habits and Medical History

(this will help us to give you the best advice possible)

How many times a day do you brush?

How long do you brush for?

Which of the following do you use in your daily brushing routine:

- | | |
|---------------------|----------|
| Manual Toothbrush | Yes / No |
| Electric Toothbrush | Yes / No |
| Floss | Yes / No |
| Interdental Heads | Yes / No |
| Mouthwash | Yes / No |
| Tongue Cleaner | Yes / No |
| Fluoride Toothpaste | Yes / No |

Do you Suffer from any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Teeth Sensitivity | <input type="checkbox"/> Pain when chewing |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Earache |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Jaw joint pain |
| <input type="checkbox"/> Teeth grinding / clenching | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Loose / shifted teeth | <input type="checkbox"/> Bad breath / taste in mouth |

If I could change my smile I would:

- | | |
|---|---|
| <input type="checkbox"/> Make my teeth brighter | <input type="checkbox"/> Make my teeth straighter |
| <input type="checkbox"/> Close spaces | <input type="checkbox"/> Repair chipped teeth |
| <input type="checkbox"/> Replace missing teeth | <input type="checkbox"/> Have a smile makeover |

If you could have your teeth whitened with our Laser whitening or Home kit whitening at an affordable cost, would you consider it?

- | | | |
|---|-----------------------------------|---|
| <input type="checkbox"/> Yes of course! | <input type="checkbox"/> Maybe... | <input type="checkbox"/> No, thank you. |
|---|-----------------------------------|---|

If you could have facial aesthetic treatments at an affordable price, would you consider any of the following?

- | | | |
|---------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Botox® | <input type="checkbox"/> Dermal Fillers | <input type="checkbox"/> Facial Peels |
|---------------------------------|---|---------------------------------------|

Please tick any of the following which apply to you:

- | | | | |
|---|--|---|---------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anaemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Excessive bleeding | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart conditions | |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Jaw pain | |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Nervousness / Depression | |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Respiratory problems | |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Scarlet fever | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cold sores | | |

Please specify any other problems that you may suffer from:

Are you currently receiving treatment from your doctor? *If yes, what for?*

Are you currently taking any medication? *If yes, please give details below:*