PATIENT INFORMATION

WELCOME to The Dental Centre. Thank you for choosing our practice for your dental needs. Please complete this form and if you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

SURNAME: **FIRST NAME:**

ADDRESS: **Mr / Mrs / Ms / Other**

POSTCODE:

DATE OF BIRTH: **OCCUPATION:**

TELEPHONE Home: **Work:**

Mobile: **e-mail:**

DENTAL HISTORY

Date of last examination: _____ Date of last dental X-ray: _____

Please tick any of the following that apply or concern you:

Your smile	☐	Colour of your teeth	☐
Appearance of your teeth	☐	Bad breath	☐
Headaches	☐	Clenching or grinding	☐
Clicking of jaw	☐	Bleeding gums	☐
Broken fillings/crowns	☐	Sensitivity of teeth	☐
Mouth ulcers	☐	Loose or drifting teeth	☐

If you could whiten your teeth for a cost anyone could afford, would you do it?: Yes ☐ No ☐

If you could change your smile, would you:

Make your teeth brighter	☐	Repair chipped teeth	☐
Make your teeth straighter	☐	Replace missing teeth	☐
Close gaps	☐	Replace old crowns	
Change shape	☐	that don't match	☐
Replace black metal fillings with tooth-coloured ones		Have a smile makeover	☐

On a scale of 1-10 (10 being the highest rating):

How important is your dental health to you?
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Where would you rate your current dental health?
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Do you use the following?: Toothbrush ☐ Dental floss ☐
Mouthwash ☐ Interdental brushes ☐

continued overleaf

MEDICAL HISTORY

Certain medical conditions can affect dental treatment, so please provide a full medical history. ALL DETAILS WILL BE KEPT STRICTLY CONFIDENTIAL

Do you smoke? Yes☐ No☐ **Do you drink alcohol?** Yes☐ No☐

Have you suffered from

	Yes	No
Rheumatic fever?	☐	☐
Any heart complaint? (including heart murmur)	☐	☐
Diabetes?	☐	☐
Epilepsy?	☐	☐
Chronic bronchitis or asthma?	☐	☐
Hepatitis?	☐	☐
Excessive bleeding	☐	☐
High blood pressure?	☐	☐
Any other serious illness?	☐	☐
Are you allergic to any medicines or tablets?	☐	☐

Names of medication(s):

	Yes	No
Are you at present taking any medicines or tablets?	☐	☐
In the past two years have you been treated with either hydrocortisone or corticosteroids?	☐	☐
Are you pregnant?	☐	☐
Are you a mother of a child under 12 months old?	☐	☐
Have you had a joint replacement operation?	☐	☐
Have you undergone any operations in the last 2 years?	☐	☐
Please tick **or tell the dentist** if you are HIV positive.	☐	☐
Have you suffered from TB?	☐	☐

If you answered 'yes' to any of the questions, please supply details above or on a separate sheet.

NAME & ADDRESS OF GP:

Tel No:

I certify that I have read and understand the above information and, to the best of my knowledge, the questions have been answered accurately. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

PATIENT/GUARDIAN SIGNATURE: **DATE:**