DENTAL MENU

Please tick the relevant boxes to help us know your current dental concerns

- ❑ Would you like your teeth to look whiter or brighter?
- ❑ Are your teeth sensitive?
- ❑ Have you any teeth you think are unsightly, mis-shapen or out of line?
- ❑ Do you have any old crowns that now do not match your other teeth or have dark lines at the gums?
- ❑ Do you have any old or stained fillings that show when you smile?
- ❑ Do you have any silver fillings that you would like replacing with tooth coloured mercury free restorations so that they blend in better?
- ❑ Do you have any missing teeth that you would like replacing to improve your smile and your bite?
- ❑ Do you have an old, worn denture that looks false and feels false?
- ❑ Are your teeth stained or your gums red and swollen?
- ❑ Do your gums bleed when brushing?
- ❑ Do you get a bad taste in your mouth or around some teeth?
- ❑ Are you concerned that you may have bad breath?
- ❑ Do you play contact sports without wearing a gum shield to protect your teeth, smile and your bite?
- ❑ Do you have frown lines or crows feet and would like treatment to soften them?
- ❑ Do you have lips that are thin and would like treatment that would "plump" them up.

DENTISTRY @ MARKETHILL

...ENJOY YOUR SMILE

MEDICAL & DENTAL HISTORY

If you are a new patient at Dentistry @ Markethill may we offer you a warm welcome. We are delighted that you have selected our practice to provide your dental care. So that we can do our best for you, we would like to ask you a few questions which will take about five minutes to answer. If you are an existing patient, we constantly aim to improve the service we offer you. Please could you take a few minutes to complete this Personal Dental Assessment.

Please tell us:

Your Surname _____

Your First name _____ Mr/Mrs/Miss/Ms/other

Date of Birth _____

Address _____

_____

_____

Postcode _____ Email address _____

Daytime number _____

Evening number _____

Mobile number _____

Occupation _____

Name and address of doctor _____

_____

PTO

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A PERSONAL DENTAL ASSESSMENT

We hope you will be very satisfied with the care you receive in our practice.
We would like to know what made you choose us. Were any of the following reasons involved?

- ❑ Convenient location
- ❑ I was recommended by a friend
- ❑ Family member already a patient here
- ❑ For emergency treatment only
- ❑ Located from website
- ❑ Telephone directory
- ❑ Another reason, please specify

When did you last visit your last dentist?

_____

Have you left another practice in order to come here? ❑ Yes ❑ No

If you think it is important to explain why, please do so.

_____

What are your reasons for attending here today?

_____
_____
_____
_____

Are you worried/anxious about seeing the dentist? Yes ❑ No ❑
Are you concerned about the finances required? Yes ❑ No ❑

PLEASE TICK THE RELEVANT BOXES TO HELP US KNOW YOUR MEDICAL / DENTAL HISTORY

ARE YOU

YES / NO

1. Attending or receiving any treatment from your doctor, hospital, clinic or specialist? ..... ❑ ❑
2. Taking any medicines or tablets prescribed by your doctor? PLEASE ATTACH DETAILS IF 'YES' ..... ❑ ❑
3. Allergic to penicillin or any other drug or substance or foods (eg latex/rubber)? ..... ❑ ❑
4. Pregnant or likely to be so? ..... ❑ ❑

CONFIDENTIAL MEDICAL HISTORY

IN THE PAST HAVE YOU

YES / NO

1. Ever had a heart problem, angina, high or low blood pressure, heart attack or stroke? ..... ❑ ❑
2. Ever had heart surgery? ..... ❑ ❑
3. Ever had rheumatic fever? ..... ❑ ❑
4. Ever had liver problems, jaundice, hepatitis, or kidney disease? ..... ❑ ❑
5. Ever had asthma, bronchitis, or any serious chest infections? ..... ❑ ❑
6. Had blood refused by the Blood Transfusion Service? ..... ❑ ❑
7. Ever had a bad reaction to a local or general anaesthetic? ..... ❑ ❑
8. Ever had an operation or received hospital treatment? ..... ❑ ❑

DO YOU

1. Have a pacemaker? ..... ❑ ❑
2. Have fainting attacks, giddiness or epilepsy? ..... ❑ ❑
3. Have diabetes? (or anyone in your family) ..... ❑ ❑
4. Carry a warning card? ..... ❑ ❑
5. Bruise easily or have you ever bled excessively? ..... ❑ ❑
6. Take or have you ever taken steroids? ..... ❑ ❑
7. Do you smoke? Typically how many per day? ..... ❑ ❑
8. Have a close relative (parent, sibling, grandparent or grandchild) with Creutzfeldt Jakob disease? ..... ❑ ❑
9. Do you regularly drink more than 14 units per week? ..... ❑ ❑
10. Suffer from headaches or migraine? ..... ❑ ❑
11. Suffer with Arthritis or have any joint replacements? ..... ❑ ❑
12. Have any infectious diseases such as HIV, CJD or Hepatitis, if so what ..... ❑ ❑
13. Have any hearing, sight impairments, or any other condition which your dentist might need to know about? ..... ❑ ❑

Reviewed_____ Initial_____ Reviewed_____ Initial_____

Reviewed_____ Initial_____ Reviewed_____ Initial_____

continued overleaf