Gentle Dental Care

Our aim is to provide excellent dental care for you, in an atmosphere which remains relaxed and friendly. We like to feel that the dental care we provide for you here is not only of the highest quality, but also that we are sensitive to your own particular needs and requirements.

This personal dental care does mean that we need to get to know you a little more about you, so we hope that you will help us by completing the simple questions in this leaflet. The answers may well affect the actual treatment we would provide for you.

Thank you for your help.

All replies are in the strictest confidence between you and your dentist; please feel most welcome to ask any questions or make any comments at any time.

REGISTRATION DETAILS:-

FULL NAME: Mr/Mrs/Miss:..

DATE OF BIRTH: ....

ADDRESS:

....

....

POST CODE:..

CONTACT TELEPHONE NO: ....

Occupation:..

What type of treatment category are you considering today? (Circle answer)

NHS Exempt   NHS Standard   NHS + Some Private   Semi-Private   Private

What is the Purpose of your visit today and what are your aims of treatment? (Check-up, Cosmetic, Pain, Whitening, Cleaning, Missing teeth discussion, Implants etc)

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When was your last dental check- up? (please **Circle** answer)

Within last 6 months   6 – 12 months   1-2 years ago   +2 years ago

How highly would you rate the importance of your appearance?

(A) In your job?   VERY/FAIRLY/NOT WORRIED

(B) In your life generally?   VERY/FAIRLY/NOT WORRIED

Is it important for you to keep your own teeth if at all possible?   YES/NO

How much do you smoke, if at all? ………………………………………..……

How much alcohol do you consume, if at all? ………………………………..…

Do you ever take sugar drinks? ………………………………………………

ABOUT YOUR DENTAL HEALTH (please **Circle** answers)

Have you had any pain from any of your teeth or in your jaw?   YES/NO

Are there any sharp edges or chipped teeth in your mouth?   YES/NO

Please circle as many as appropriate, if your teeth sensitive to :-

Hot/cold things   Sweet things   Bite, chew on or touch

GUMS-

Please circle as many as appropriate, if your Gums :-

Bleed on brushing   Tender/Sensitive areas   Receding or shrinking

Do you get a bad taste in your mouth?   YES/NO

APPREARENCE

Are you happy with the Colour of your teeth?   YES/NO

Is there anything about the Appearance, Shape, or Position of your teeth that you would like to improve or discuss?   YES/NO

OTHER

Do you find it difficult to eat, bite, chew your food properly?   YES/NO

Do you suffer from headache, migraine or facial pain?   YES/NO

Does your jaw ever "click" or get stuck?   YES/NO

Do you suffer from any ulcers or any sore areas in your mouth?   YES/NO

If you wear dentures, how happy with them are you?   VERY/FAIRLY/NOT HAPPY

Do any of your teeth feel loose?   YES/NO

ANXIETY

Do you worry about your dental visit, and if so what worries you the most?

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ABOUT YOUR GENERAL HEALTH - Do you suffer from, or have ever suffered from:-

1. **Heart disease, heart murmur, any other kind of heart problem? YES/NO**
2. **High or low blood pressure? YES/NO**
3. **Bronchitis, asthma, or any kind of chest problems? YES/NO**
4. **Diabetes (and if so when was it diagnosed)? YES/NO**
5. **Dizziness, blackouts, giddiness, fainting? YES/NO**
6. **Jaundice or other liver disorders, including hepatitis? YES/NO**
7. **Epilepsy or any kind of fit? YES/NO**
8. **Digestive problems? YES/NO**
9. **Abnormal or excessive bleeding from injections or tooth extractions? YES/NO**
10. **Any other serious illness? YES/NO**
11. **Allergic reactions to any medication (Penicillin, Latex) foods/drinks, pollen (hay fever) or other material?**
12. **Are you taking any medicines, pills, or tablets of any kind, or receiving any other regular medication or treatment? (Give details below)**
13. **Have you ever had a positive blood test for A.I.D.S., Hepatitis or any other blood- borne disease? YES/NO**
14. **Do you bruise easily? YES/NO**
15. **Have you ever been in hospital for observations or an operation? YES/NO**
16. **Who is your normal doctor (give the address of the surgery you attend if possible)**

Thank you, **PLEASE SIGN TO VERIFY THAT THE DETAILS GIVEN ARE COMPLETE CORRECTLY.**
YOUR DENTIST WILL CHECK THIS QESTIONAIRE THROUGH WITH YOU.
IF THERE IS ANYTHING YOU WOULD LIKE TO MENTION, PLEASE FEEL FREE TO DO SO.
Signed ………………………………………………… Date…………………………………………