Personal Dental Assessment

Welcome to Dental Sense. For us to ensure that we can provide you with the most appropriate dental care, we kindly ask you to complete the following questions. Any information that you provide is held within strictest confidence at the practice.

Surname: ………………………..

First name(s):……….…………..

Title..............**DoB**:……/……/.….

Address:…………………………..

……………………….…………

………………………….....……

Post Code: ………………………

Tel 1(h)…..……..….…………….

Tel 2 (w/m)…...…………………...

Occupation: ………..…………..

e-mail: ……………………………

Date of last Dental Visit:

………………….…………………..

NHS Number:

……………………………………...

Do you have Dental Insurance:
Yes/No
Provider:…………………………

How did you hear about us?
Recommended by friend or family
Internet Practice leaflet
Sign/shop frontage
Other Advertising

Medical Doctor Name & Address

Emergency Contact Name & Tel.

Please tick and provide details, in the space provided:

	Yes	No	**Details of Medical Condition, Current / Pass Medical Treatment and Medications taken and Medication currently taking**
Are you in good **General Health**?			
HEART- damaged or replaced heart valves, angina, previous rheumatic fever, a pacemaker?			
CHEST- asthma, shortness of breath?			
BLOOD PRESSURE (High or Low?) **please state**			
BLOOD - Anaemia, prolonged bleeding?			
LIVER / KIDNEY DISEASE?			
NERVOUS SYSTEM - Epilepsy?			
JOINTS & BONES - Arthritis, Artificial joints?			
SKIN - Eczema?			
INFECTIOUS AGENTS – HIV / AIDS, Hepatitis, TB?			
ALLERGIES to any drugs or material? e.g. Penicillin, Latex?			
Do you have **DIABETES**?			
Do you **SMOKE**?			
Have you taken **Steroid medicine** in the past 2yrs?			
Are you taking medicines to thin your blood? e.g. **Warfarin, Aspirin**			
Are you taking **Bisphosphonate medication**? e.g. Fosamax			
Any other **Serious illness's** or **Surgery**?			
Female patients: Are you Pregnant?			
Are you taking the Oral Contraceptive Pill?			

Are you happy with your smile? Yes / No
Would you like your teeth to look whiter or brighter? Yes / No
Do you have sensitive teeth? Yes / No
Do you have any teeth that are unsightly or crooked? Yes / No
Are you concerned about any old crowns that do not match? Yes / No
Do you have any missing teeth that you would like to replace? Yes / No
Would you prefer tooth coloured fillings to replace any silver ones? Yes / No
Do you consider yourself a nervous patient? Yes / No
Would you be interested in comprehsive dental care? Yes / No
What (if anything) would you like to change about your teeth? ....
.... ……………………………………………………………………………
…………………………………………………….

I have completed this Questionnaire to the best of my knowledge, and understand that failure to disclose all information may place ME at undue medical risk. I also give my permission for the practice to use the above contact details to call or send me appointment and check-up reminders.

Patient Signature
_____________________________ Date___________ [Dentist Signature ______________]