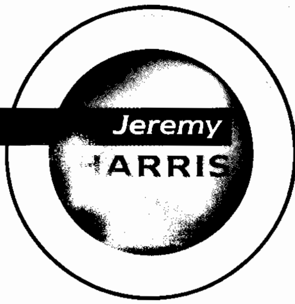


Dental Assessment

When did you last visit your dentist? ____________________

Please list any concerns you have at the moment about your dental health?

____

____

Which of the following statements best describes your feelings about visiting the dentist?

- ◯ I feel relaxed
- ◯ I feel a little anxious
- ◯ I feel very anxious and nervous

Are there any dental procedures which you are particularly anxious about?

____

◯ These days a lot can be done to prevent the need for dental treatment, such as fillings. Tick here if you would like to know more about this preventive approach to your own/your children's dental care?

SmileCheck ✔

- ◯ I have unreplaced missing teeth
- ◯ My gums bleed when I brush my teeth
- ◯ Parts of my mouth are sensitive to temperature or pressure
- ◯ Food gets caught between my teeth
- ◯ I have an unpleasant odour/taste in my mouth
- ◯ I am not totally satisfied with my teeth and their appearance
- ◯ I am self conscious about my teeth when I smile
- ◯ I wish my teeth were whiter
- ◯ I wish my teeth were shaped differently
- ◯ Some of my teeth are irregularly positioned
- ◯ Some of my teeth are discoloured
- ◯ My front teeth have filings which do not match the colour of my other teeth
- ◯ I wish the fillings in my back teeth were tooth coloured instead of black

If I could alter my smile I would most like to change:

____

Signed ____________________ Date ____________________

Thank you for taking the time to answer our questions

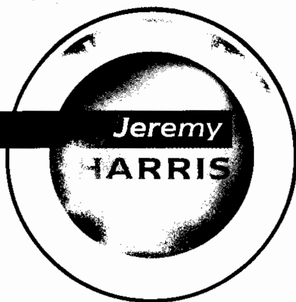
Are you in any Private Medicine Scheme or Hospital scheme which allow full/part refund of your dental charges?

Yes No

Which scheme are you a member of?

Would you like details of dental care plans available?

Yes No



About You

Please complete BOTH sides of this form and return it in the SAE provided before your next appointment

If you are a new patient at Law Court Dental Health 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 here we constantly aim to improve the service we offer you. Please could you take a few minutes to complete the Dental Assessment overleaf and bring it with you to your next visit.

Full Name ____________________

Address ____________________

____

____________________ Postcode ____________________

Tel (day) ____________________ Tel (eve) ____________________

Date of birth ____________________ Occupation ____________________

Do you have children? ◯ Yes ◯ No Age(s) if 'yes' ____________________

We would like to know what made you choose us:

◯ Convenient location

◯ Recommended by a friend

◯ Family member already a patient

◯ Referred by another dentist

◯ Located from the Yellow Pages

◯ Other, please specify: ____________________

Have you left another practice in order to come here? ◯ Yes ◯ No
If yes, explain here if wished:

____

Medical History

So that we are able to give you the best and most appropriate treatment possible we need to know whether you are having any medical treatment or taking pills, medicines or drugs. It will also help if we know of any illness in the past. Please tick the YES or NO boxes alongside each question.

	Yes	No
Are you receiving treatment from any doctor, hospital or clinic?	◯	◯
Are you, or have you in the last 6 months, regularly taken medicines, drugs, tablets etc, of any sort, prescribed or of your own accord? If so, please list: ____________________	◯	◯
Have you ever been prescribed Steroids?	◯	◯
Do you suffer with chest pain or shortness of breath?	◯	◯
Have you ever had heart trouble or blood pressure trouble?	◯	◯
Have you ever had rheumatic fever?	◯	◯
Do you have chest trouble, e.g bronchitis/asthma?	◯	◯
Have you had jaundice, liver disease or kidney disease?	◯	◯
Have you ever had an unusual reaction to a general anaesthetic?	◯	◯
Have you ever had abnormal bleeding after extractions?	◯	◯
Do you suffer from hay fever, eczema or asthma?	◯	◯
Have you any allergies, e.g. do you react to Penicillin?	◯	◯
Do you have sudden fainting attacks, giddiness or fits?	◯	◯
Are you an expectant mother?	◯	◯