

Y O U A N D Y O U R F A M I LY

Patient’s full name:

Address:

Title: ****Mr ****Mrs ****Ms ****Dr ****Miss ****Other Post code:

Date of birth: Phone(H): Mobile:

Email address:

Occupation:

Business address:

Post code: Phone:

Hobbies and interest

Emergency contact: Relationship to patient:

Address:

Post code: Phone:

Name of person(s) responsible for fees:

Address: (Complete only if different to above)

Post code Phone:

Email Address:

Do you have dental insurance? Yes**** No**** If yes, which fund?

How did you find out about us? **** Family dentist **** Yellow pages **** Friend \_\_\_\_\_\_\_\_ **** Relative **** Website **** Other

Y O U R D E N TA L H E A LT H

What is your dentist’s name?

Address:

Post code: Phone:

When was your last dental examination?

Have you ever had any injuries to the face, mouth or teeth? ****Yes **** No

Have you ever sucked a thumb or fingers? Until what age? **** Yes **** No

Do you have any speech problems? **** Yes **** No

Do you have any jaw problems (e.g clicking, locking)? **** Yes **** No

Have you ever had any serious problems with dental treatment? **** Yes **** No

Does anyone else in the family have an orthodontic problem? ****Yes **** No

Has anyone else in the family had orthodontic treatment? **** Yes **** No

What is your main concern regarding your teeth?



Y O U R G E N E R A L H E A LT H

What is your doctor’s name?

Address:

Post code: Phone:

Have you ever had any of the following:

High blood pressure ****Yes **** No

Heart problems ****Yes **** No

Asthma or breathing problems ****Yes **** No

Rheumatic fever ****Yes **** No

Autism Spectrum Disorder ****Yes **** No

Tuberculosis ****Yes **** No

Stomach or bowel problems ****Yes **** No

Kidney disease ****Yes **** No

Diabetes ****Yes **** No

Thyroid problems ****Yes **** No

Excessive bleeding or blood disorder ****Yes **** No

Epilepsy ****Yes **** No

Hepatitis ****Yes **** No

AIDS/HIV ****Yes **** No

Joint problems or arthritis ****Yes **** No

List any other previous illnesses

Are you currently taking any tablets or medicines? ****Yes **** No

If yes, please list

Have you ever stayed in hospital, had an operation, or a general anaesthetic? ****Yes **** No

If yes, please provide details

Do you have an artificial hip, heart valve or other prosthetic implant? ****Yes **** No

Are you allergic to any medicines or products (e.g. penicillin, latex)? ****Yes **** No

If yes, please list

Females, are you pregnant? ****Yes **** No

Do you smoke? ****Yes **** No How many? /day Would you like to stop? ****Yes **** No

I have completed this questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place me at undue medical risk. I understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and I consent to this. I also give my permission for the practice to use the above contact details to send me appointment and check-up reminders.

Signature:

Please print name: Date: