DENTAL HISTORY

By completing the following dental history, you will help us to give you the best dental care possible

1. When was the last time you saw a dentist?
2. Who was your last dentist?
3. How often did you visit your previous dentist?
4. Are you nervous about seeing the dentist?
5. Do you see a hygienist regularly?
6. Have you had advice about oral hygiene?
7. How many times a day do you brush your teeth?
8. Do you use an electric toothbrush?
9. Do you floss? If so, how many times a day and week?
10. Do you use mouthwash? If so, how many times a day do you use it?
11. Would you like advice about a healthy diet?

We have an in-house qualified dietician at the practice.

12. Do your gums bleed?
13. Are any of your teeth sensitive to hot or cold?
14. Have you had any wisdom teeth removed?
15. Does your jaw click when you open and close your mouth?
16. Do you clench or grind your teeth?
17. Do you snore?

If yes, would you consider wearing an appliance at night to help you to stop snoring?

18. Would you like your teeth to be whiter?
19. Is there anything that concerns you about your dental health?

PATIENT REF NO.

WELCOME
THANK YOU FOR SELECTING US

Welcome to Pitshanger Dental Care. We would like to take care of your individual dental needs, so please help us by filling in this confidential questionnaire completely. Please feel free to ask the dentist and staff at the practice any questions regarding your treatment, appointments or fees.

PLEASE PRINT IN CAPITALS

Mr Mrs Miss Other……(please circle)
Surname:……
Home tel: ……
First name:……
Work tel: ……
Address:……
Mobile no: ……
E-mail:……
Doctor's name:……
Postcode:……
Doctor's address:……
Date of birth:……
Occupation:……
Doctor's tel. no:……

How did you hear about Pitshanger Dental Care?

By recommendation, if so whom?.....
Yellow pages / Thompson's directory.
Newspaper.
Internet.
Referral by another dentist.
Other, please specify.....

Do you have dental insurance? If so, which one?.....
BUPA / DENPLAN / CIGNA / OTHER
If not, would you like information on dental insurance? Yes No
Have you left another practice to come here? Yes No
If so why?.....

I understand that I will undertake to pay any necessary fees and will be liable for any missed or late cancellation of appointments. 24 hours are required for cancellation of appointments with the dentist and 48 hours for appointments with the hygienist.

Signed……..(Parent/Guardian) Date……..

Medical History

To provide the best and safest treatment possible, your dentist needs to know of any problems, which may affect your treatment.

	YES	NO	IF YES, PLEASE GIVE DETAILS
Are you attending or receiving treatment from a doctor, clinic, hospital or specialist?			
Are you taking any medicines, tablets, drugs, injections, using creams, ointments or inhalers?			
Are you taking or have you had steroids in the last two years?			
Are you allergic to penicillin?			
Are you allergic to any medicines, foods or materials?			
Are you HIV positive?			
Have you had rheumatic fever or chorea?			
Have you had jaundice, liver, or kidney disease or hepatitis?			
Have you ever been told that you have a heart murmur, heart problem, angina or high blood pressure?			
Have you ever had your blood refused by the blood transfusion service?			
Have you ever had a bad reaction to a local or general anaesthetic?			

	YES	NO	IF YES, PLEASE GIVE DETAILS
Have you ever had a joint replacement or other implant?			
Have you been hospitalised for any reason?			
Do you have arthritis?			
Do you have a pacemaker or have you had heart surgery?			
Do you have fainting attacks, giddiness, blackouts or epilepsy?			
Do you suffer from hay fever, eczema or any other allergy?			
Do you suffer from bronchitis, asthma or other chest conditions?			
Does anybody in your family have diabetes?			
Do you or anyone in your family bruise easily or suffer from persistent bleeding following a tooth extraction or injury?			
Are you pregnant? If yes, when is the baby due?			
Do you carry a warning card?			
Do you smoke or chew tobacco? If so, how many a day?			
Do you drink alcohol? If so, how many units a week?			
Do you eat betel nuts?			