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forestdental
GENTLE FAMILY DENTISTRY

personal dental assessment

If you are a new patient at our practice 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 at our practice we constantly aim to improve the service we offer you. Please take a few minutes to complete this questionnaire.

Your full name

❑ Mr ❑ Mrs ❑ Ms ❑ Miss ❑ Dr ❑ Other

Email

Address

Postcode Date of Birth

Daytime number

Evening number

Work number

Please state how you selected our practice:

❑ Convenient location
❑ Recommended by friend/family
❑ Internet search
❑ Other

Which is the best day/time for you to attend for your dental appointments?

Mon ❑ am ❑ pm
Tues ❑ am ❑ pm
Wed ❑ am ❑ pm
Thurs ❑ am ❑ pm
Fri ❑ am ❑ pm

How would you like to receive reminders about booked appointments?

❑ Telephone ❑ Email

Do you use social media?

❑ Twitter ❑ Facebook ❑ None

We will be delighted if you will follow us on Twitter or like us on Facebook so you can receive our latest offers and advice.

healthy smile profile

Please tick the relevant boxes to help us assess your current dental needs:

❑ I am self-conscious about my teeth when I smile
❑ I wish my teeth were whiter
❑ I am unhappy with the shape of my teeth
❑ I think my teeth are too large/small
❑ I wish my teeth were straighter
❑ I have gaps that show
❑ I cover my mouth with my hand due to my smile
❑ I have black/silver fillings in my mouth which I would like to replace with tooth coloured fillings
❑ I have sensitive teeth
❑ I have old crowns that now do not match my other teeth or have dark lines around the gums
❑ I am worried about cracks in my teeth
❑ I have fractured my teeth in the past
❑ I am aware of clenching/grinding my teeth
❑ I am concerned that I may have bad breath
❑ My gums bleed when I brush them
❑ I get a bad taste in my mouth
❑ My dentures are uncomfortable, and they look / feel like dentures
❑ Some of my teeth are dark, chipped or misshapen
❑ I am concerned about the cost of treatment and how to pay for it

Do you play contact sports without wearing a gum shield to protect your teeth, smile and your bite?

❑ Yes ❑ No

I would like to discuss spreading the cost of my routine dental care by joining the Forest Dental Membership Plan (starts from £5 per month)

❑ Yes ❑ No

I would like to discuss spreading the cost of my dental treatment with 0% finance

❑ Yes ❑ No

PLEASE COMPLETE THE REVERSE OF THIS FORM

confidential medical history

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are you...

1. Receiving any treatment from your doctor, hospital, clinic or specialist? YES / NO .....
2. Taking any medicines or tablets prescribed by your doctor? Please list if 'YES' YES / NO .....
   .....
   .....
3. Allergic to penicillin or any other drug or substance or foods (e.g. latex/rubber)? YES / NO .....
4. Pregnant? YES / NO .....
5. Breast feeding? YES / NO .....

in the past have you....

1. Ever had a heart problem, angina, heart attack or stroke? YES / NO .....
2. Ever had high or low blood pressure? YES / NO .....
3. Ever had a heart valve replaced? YES / NO .....
4. Ever had rheumatic fever? YES / NO .....
5. Ever had jaundice, hepatitis, liver problems or kidney disease? YES / NO .....
6. Ever had asthma, bronchitis or any serious lung condition? YES / NO .....
7. Had a blood transfusion from the Blood Transfusion Service? YES / NO .....
8. Ever had any blood related diseases? YES / NO .....
9. Ever had a bad reaction to a local anaesthetic? YES / NO .....
10. Ever had an operation or received hospital treatment? YES / NO .....

do you....

1. Have a pacemaker? YES / NO .....
2. Have fainting attacks, giddiness or epilepsy? YES / NO .....
3. Have diabetes? YES / NO .....
4. Carry a warning card? YES / NO .....
5. Bruise easily or have you ever bled excessively? YES / NO .....
6. Take or have you ever taken steroids? (If yes, please state which year) YES / NO .....
7. Smoke? Typically how many per day? YES / NO .....
8. Drink alcohol? If YES how many units per week? YES / NO .....
   (a unit is half a lager, a single measure spirit or glass of wine)
9. Suffer from headaches or migraine? YES / NO .....
10. Suffer from hay fever? YES / NO .....
11. Suffer with cold sores? YES / NO .....
12. Suffer with Arthritis or have any joint replacements? YES / NO .....
13. Have any infectious diseases such as HIV, CJD or Hepatitis, if so what YES / NO .....
14. Have any hearing or sight impairments? YES / NO .....
15. Have any physical or mental disabilities? YES / NO .....