

## St Mellion Dental Clinic New Patient Questionnaire

Title:	Forename(s):			
Surname:		Date of birth:		
Address:				
			Postcode:	
Telephone; Home:		Work:		
Mobile:		E-mail:		
I prefer to be contacted by: (delete as applicable)	Post	E-mail	SMS message	Telephone
Messages may be left: (delete as applicable)	With a family member		On an answerphone	

Do you have any discomfort from your mouth?	NO	YES	<i>If YES, please describe the pain, e.g. top or bottom, left or right, sharp pain or dull ache:</i>
Are you aware of any problems (e.g. broken teeth, lost fillings)?	NO	YES	<i>If YES, what?</i>

### Your Smile Analysis Please look into the mirror and evaluate your smile

How many teeth do you show when you smile?				
My teeth seem too dark	YES		NO	
How would you describe their colour and shade?	Very white	Moderate - white	Light – yellow	Moderate – yellow
	Dark – yellow	Light -brown	Dark -brown	Grey
Do your front teeth have any unsightly fillings or crowns?	YES		NO	
Are your teeth crowded together?	YES		NO	
Is there anything you would like to mention about your smile?				

How long since your last routine dental examination?	Years		Months	
What is your <u>main</u> concern about your teeth/mouth?	HEALTH	BEAUTY	FUNCTION	COMFORT

How do you feel about visiting the dentist?	CONFIDENT	NERVOUS	TERRIFIED
How did you hear about us?	YELLOW PAGES	INTERNET	PERSONAL RECOMMENDATION
If someone recommended us to you, please give us their name so we can thank them.			

I understand that it is my responsibility to inform the clinic of any changes to the information given on this form.	
Signed:	Date:

<b>Medical form for:</b>			<b>Date:</b>
<b>ARE YOU CURRENTLY:</b>	<b>NO</b>	<b>YES</b>	<b>FULL DETAILS</b>
Pregnant?			<i>(Due date)</i>
Receiving treatment from a doctor, hospital or clinic?			<i>(Details)</i>
Taking any prescribed medicines (e.g. Tablets, ointments, injections or inhalers, including HRT and contraceptives)?			<i>(Names of medicines)</i>
Carrying a Medical Warning Card or other MediAlert device			<i>(Details)</i>
<b>DO YOU SUFFER FROM:</b>			
Allergies to any medicines (e.g. Penicillin), substances (e.g. Latex) or foods?			<i>(What are you allergic to)</i>
Hay fever or eczema?			<i>(Details)</i>
Bronchitis, asthma or other chest condition?			<i>(Details)</i>
Fainting attacks, giddiness, blackouts or epilepsy?			<i>(Details)</i>
Heart problems, angina, blood pressure problems or stroke?			<i>(Details)</i>
Osteoporosis or bone tumours?			<i>(Details)</i>
Diabetes (or does anyone in your immediate family?			<i>(Details)</i>
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			<i>(Details)</i>
Any infectious diseases (including HIV & Hepatitis)?			<i>(Details)</i>
Cold sores?			
<b>DID YOU, AS A CHILD OR SINCE, HAVE:</b>	<b>NO</b>	<b>YES</b>	<b>FULL DETAILS</b>
Rheumatic Fever or Chorea?			<i>(Details)</i>
Liver disease (e.g. jaundice, hepatitis) or kidney disease?			<i>(Details)</i>
Any other serious illness?			<i>(Details)</i>
A bad reaction to general or local anaesthetic?			<i>(Details)</i>
A joint replacement or other implant?			<i>(Details)</i>
Treatment that required you to be in hospital?			<i>(Details)</i>
Heart surgery?			<i>(Details)</i>
Brain surgery?			<i>(Details)</i>
	<b>YES</b>	<b>NO</b>	<b>IN PAST QUANTITY</b>
<b>SMOKING:</b> Do you smoke any tobacco products now (or have you in the past)? How many a day?			
<b>PLEASE GIVE ANY OTHER DETAILS WHICH WE MIGHT NEED TO KNOW ABOUT, SUCH AS SELF-PRESCRIBED MEDICINES.</b>			
<b>NAME &amp; ADDRESS OF YOUR DOCTOR:</b>			
<b>Dr</b>			<b>Surgery/Clinic/Health Centre</b>
<b>FORM COMPLETED BY (Delete as applicable)</b> Self                      Parent                      Guardian			
<b>SIGNATURE</b>			