

Smile Menu

LET US HELP YOU TO IMPROVE YOUR MOUTH AND SMILE

Please tick the relevant boxes to help us know your current dental concerns

	YES	NO
Are you happy with the appearance of your teeth/gums/smile ?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to discuss enhancing the appearance of your smile ?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to discuss how to make your teeth WHITE ?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive?	<input type="checkbox"/>	<input type="checkbox"/>
Have you any teeth you think are unsightly, mis-shapen or out of line?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any old crowns that now do not match your other teeth or have dark lines at the gums?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any old or stained fillings that show when you smile?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any silver fillings that you would like replacing with tooth coloured mercury free restorations so that they blend in better?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any missing teeth that you would like replacing to improve your smile and your bite?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an old, worn denture, or an NHS denture that looks false and feels false?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth stained or your gums red and swollen?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when brushing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get a bad taste in your mouth or around some teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are you concerned that you may have bad breath?	<input type="checkbox"/>	<input type="checkbox"/>
Do you play contact sports without wearing a gum shield to protect your teeth, smile and your bite?	<input type="checkbox"/>	<input type="checkbox"/>

What don't you like about your smile ?.....
.....
.....

Date..... Date..... Date..... Date..... Date.....

Signature..... Signature..... Signature..... Signature..... Signature.....



www.asmileclinic.co.uk

medical & dental history

Name.....

Personal Dental Assessment

If you are a new patient at A Smile Clinic 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 A Smile Clinic we constantly aim to improve the service we offer you. Please could you take a few minutes to complete this Personal Dental Assessment and bring it with you to your next visit.

PLEASE TELL US...

Title _____

Your full name _____

Address _____

Postcode _____

Home number _____

Mobile number _____

Work number _____

Email _____

Date of birth _____

What is your occupation? _____

Name and Address of your doctor

We hope you will be very satisfied with the care you receive in our practice. We would like to know what made you choose us. Were any of the following reasons involved?

- Convenient location
- I was recommended by a friend
- Convenient surgery hours
- Family member already a patient here
- For emergency treatment only
- Referred by another dentist
- Located from Yellow Pages
- Located from local advertising
- Web / Internet
- Another reason, please specify

When did you visit your last dentist?

Have you left another practice in order to come here? Yes No

If you think it is important to explain why, please do so.

Confidential Medical History

A. ARE YOU...

1. Attending or receiving any treatment from your doctor, hospital, clinic or specialist? YES / NO
2. Taking any medicines or tablets prescribed by your doctor? **PLEASE LIST OR ATTACH COPY** YES / NO
-
3. Allergic to penicillin or any other drug or substance or foods (eg latex/rubber)? YES / NO
4. Pregnant or likely to be so? YES / NO

B. IN THE PAST HAVE YOU...

1. Ever had a heart problem, angina, high or low blood pressure, heart attack or stroke? YES / NO
2. Ever had rheumatic fever? YES / NO
3. Ever had jaundice, hepatitis, liver problems or kidney disease? YES / NO
4. Ever had asthma, bronchitis, hayfever or any serious chest infections? YES / NO
5. Ever had any blood related diseases? YES / NO
6. Ever had a bad reaction to a local or general anaesthetic? YES / NO
7. Ever had an operation or received hospital treatment? YES / NO
8. Ever had a heart valve replaced? YES / NO
9. Had a blood transfusion from the Blood Transfusion Service? YES / NO
10. Had growth hormone treatment before the mid 1980's? YES / NO

C. 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? YES / NO
7. Do you smoke? Typically how many per day? YES / NO
8. Have a close relative (parent, sibling, grandparent or grandchild) with Creutzfeldt Jakob disease? YES / NO
9. Drink alcohol (A unit is half a lager, a single measure spirit or glass of wine)? YES / NO How many units per week?
10. Suffer from headaches or migraine? YES / NO
11. Suffer from Arthritis? YES / NO
12. Have any infectious diseases such as HIV, CJD or Hepatitis, if so what YES / NO

Are there any other aspects concerning your health that you think we should know about ?

.....

.....