

115 Alexandra Park Road, London N10 2DP | Tel: 020 3355 0552

**Personal Assessment and Medical History Form**

**PRIVATE AND CONFIDENTIAL**

First name …………………………………………… Family name ………………………………………………..........

Date of birth ……………………………… Mr Mrs Ms Miss Occupation……......................................

Email address…………………………………….............................................................................................................. .

Address…………………………………………………………………City……………… Postcode........................... Mobile no ………………………………………….............. Home phone no...........………………............. Last visited a dentist date …………………………….......

 How did you hear about us: Leaflet □ Internet □ Walked by □ GP □ Recommended by……………………………………………….............................................

Dental Questionnaire

|  |  |  |
| --- | --- | --- |
| ■ Do your gums bleed when you brush your teeth? | Yes □ | No □ |
| ■ Do you get food trapped between your teeth? | Yes □ | No □ |
| ■ Do you have any concern about your breath? | Yes □ | No □ |
| ■ Would you like to have whiter teeth? | Yes □ | No □ |
| ■ Are you concerned with crooked or crowded teeth? | Yes □ | No □ |
| ■ Would you like to improve the look of your smile? | Yes □ | No □ |

■ What type of tooth brush do you use? soft□ medium□ hard□ electric□

I have a dental Insurance □ Name of Insurance.................................................

I wish to be seen at the practice as a patient □ as a member □

Your Doctor’s (GP) name & address...................................................................................... ..........................................................................................................................................................................................................................................................................................................................

**Are you currently: Yes NO PLEASE GIVE DETAILS**

Receiving treatment from a doctor or hospital?

Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers)?

Allergic to any medication, food or substance? (penicillin, latex)

**Have you: Yes No PLEASE GIVE DETAILS**

Been told that you have heart problems, angina, blood pressure problems, or stroke?

Had bruising or persistent bleeding following injury, tooth extraction or surgery?

Had liver disease (e.g. jaundice, hepatitis) or kidney disease?

A bad reaction to general or local anaesthetic?

Had your blood refused by the Blood

Transfusion Service?

Had rheumatic fever or chorea?

Had arthritis or joint replacement?

**Do you: Yes No PLEASE GIVE DETAILS**

Have a pacemaker or have had any heart surgery?

Suffer from bronchitis, asthma or other chest condition?



Have diabetes (or does anyone in your family)?



Suffer from hay fever or eczema?



Any infectious diseases (including HIV and hepatitis)?



Fainting attacks, giddiness, blackouts, epilepsy?



Carry a warning card?



Any other serious illness?



Are there any other aspects concerning your health that you think the dentist should know about? ………………………………………………………………………………………………………………………..

Are you, or do you think you may be pregnant? Yes □ No □ Due on ……………………

Do you smoke? If so how many cigarettes a day? No □ 1-10 □ 11-30 □ 30+□

Alcohol consumptions units per week: None □ 1-5 □ 5-10 □ 10+□

I understand and agree to the following:

■ When I accepted my Treatment Plan, payment will be made in full by the end of visit.

■ Clinical photographs and radiographs might be taken for my treatment records

 ■ I may be asked for an advanced payment for planned treatments and it will be a charge for appointment rebooked, missed or cancelled without 24/48 hours notice. Please see our full cancellation policy.

Signature…………………………………………………… Date………………………………………………

Please kindly tell the dentist if you have any health issues or disability that the practice should be aware of to ensure that our services are appropriate to your needs. Many Thanks