Smile check

Personal dental assessment

Before we do a clinical examination, it is very important for us to understand how you perceive your dental health. This short self-assessment enables us both to look at things from your perspective and helps determine how best to care for you.

How long is it since your last dental examination?

○ 6 months ○ One year ○ 2 Years ○ Longer

When you visit the dentist, do you feel

○ Relaxed ○ A little anxious ○ Very nervous

Please indicate with a tick what is true for you	Yes	No
My teeth are occasionally sensitive		
My jaw and facial muscles sometimes ache		
I like the shape and size of my teeth		
I have frequent headaches		
My gums bleed when I brush my teeth		
I am happy with the colour of my fillings		
I play a contact sport		
I can smile confidently		
My breath has a poor odour		
I like the colour of my teeth		
I can chew food easily and comfortably		
I like the position of my teeth		

On a scale of 1-10 (where 1 is dissatisfied and 10 is delighted) please indicate how you would rate your dental health by circling the appropriate value on the scale.

1 2 3 4 5 6 7 8 9 10

On a scale of 1-10 (where 1 is dissatisfied and 10 is delighted) please indicate how you would rate the appearance of your teeth by circling the appropriate value on the scale.

1 2 3 4 5 6 7 8 9 10

Would you like to know more about:

○ Adult braces ○ Tooth whitening ○ Anti-snoring devices
○ Dental implants ○ Stain removal ○ Facial aesthetics

We would love to know where you heard about us, please tick the relevant boxes.

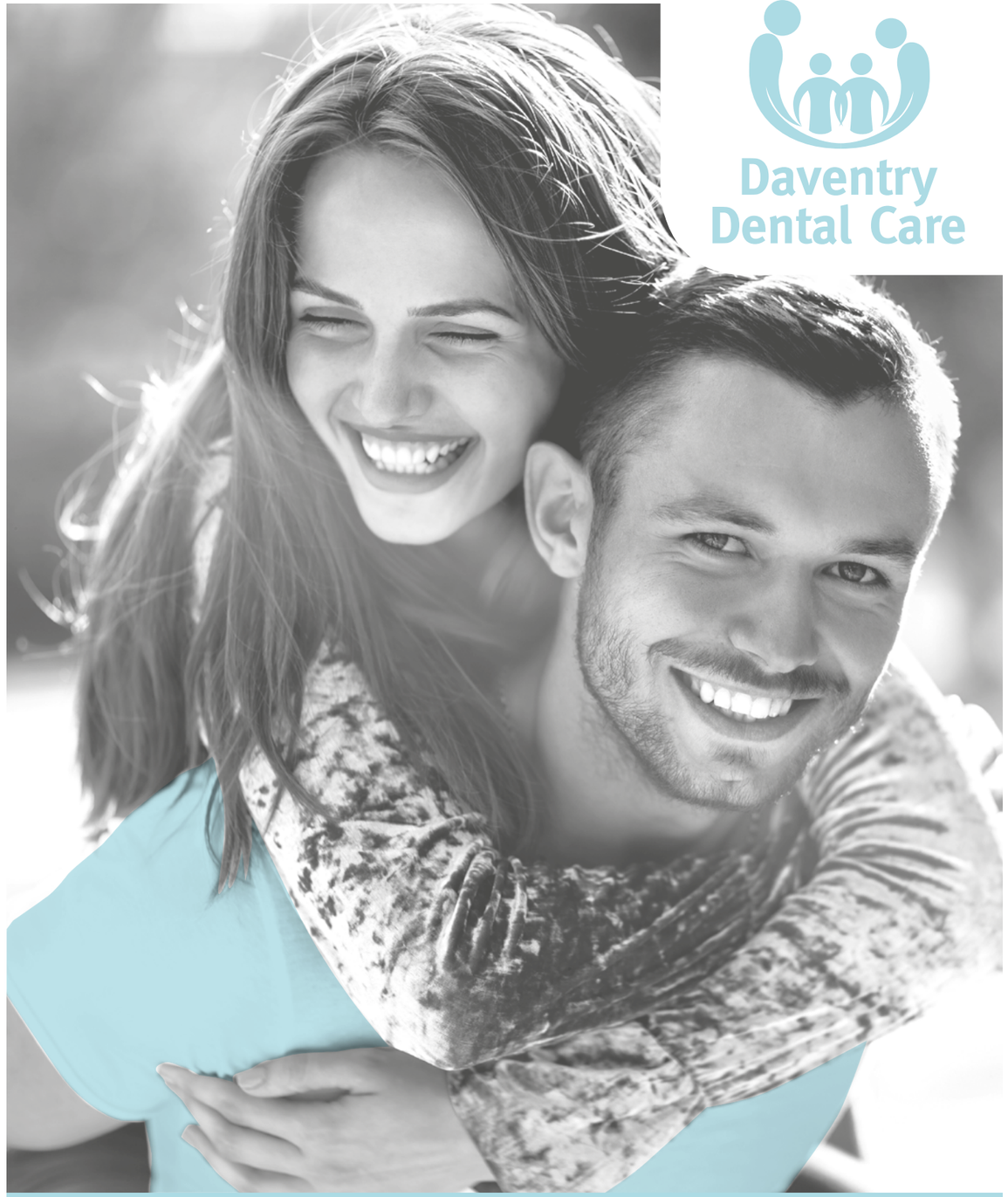
○ Local in your area ○ Family already a member here ○ Referred by another dentist
○ Recommended by a friend ○ Advert in magazine or newspaper ○ For emergency treatment only
○ Internet ○ Other, please specify.....

Patient Signature:..... Date: .....

Dentist Name:..... Date: .....

Dentist Signature:.....

Thank you for completing this form. It will help us to treat you safely.



Daventry Dental Care

Medical & Dental History Form

Daventry Dental Care

First Floor Offices • 34 Sheaf Street • Daventry • Northamptonshire NN11 4AB

Tel: 01327 878758 • www.daventrydental.com

Patient Information

Medical and dental history

We ask you for information about your dental health so that we can discuss your particular needs and concerns, and help you to choose the best treatment plan where applicable.

We also need to know your medical history, in order to give us a greater understanding of what is happening inside your mouth. It also means that we know what medication to avoid and what advice to give you.

This information will be kept strictly confidential.

This form might look a little long, but we have designed it to be as easy to complete as possible – it should only take a few minutes of your time.

Name: ..... Occupation: .....

Address: .....

..... Postcode: .....

Date of birth: ..... Telephone: .....

Email: .....

Signature: ..... Date: .....

GP Name: .....

Address: .....

..... Telephone: .....

Emergency Contact Name: .....

Relationship: ..... Telephone: .....

How long is it since your last dental examination? Six months ○ One year ○ Two years ○ Longer ○

Do you currently have any pain or concerns? Yes ○ No ○ .....

What particularly triggers this? .....

Do you smoke? Yes ○ No ○ If yes, how many per week? .....

Do you drink? Yes ○ No ○ If yes, how many units per week? .....

If you are completing this form for a child who is aged under 18 years, please answer the following questions:

Do you feel your child's teeth are discoloured? ..... Yes ○ No ○

Do you feel your child's teeth are crooked? ..... Yes ○ No ○

Does your child swallow their toothpaste? ..... Yes ○ No ○

Do you give your child fluoride drops or tablets? ..... Yes ○ No ○

Please complete the following:

Are you attending or receiving treatment from a doctor, hospital or clinic? ..... Yes ○ No ○

If yes, please give details: .....

Are you pregnant or trying to conceive? ..... Yes ○ No ○

Please give your due date if applicable: .....

Are you a nursing mother? ..... Yes ○ No ○

If yes, please give your child's date of birth: .....

Are you diabetic? ..... Yes ○ No ○

Are you on a low sodium diet? ..... Yes ○ No ○

Are you taking any medication? ..... Yes ○ No ○
(tablets, medicines, ointments, inhalers, patches, etc.)

If yes, please list them: .....

Have you had, or do you have, any of the following:

Allergies (e.g. to penicillin, latex, aspirin, chlorhexidine or certain foods)? ..... Yes ○ No ○

Rheumatic fever or chorea? ..... Yes ○ No ○

Heart trouble of any kind (e.g. angina, heart murmurs, blood pressure problems, etc.)? ..... Yes ○ No ○

Stroke? ..... Yes ○ No ○

Lung problems (e.g. asthma, bronchitis, etc.)? ..... Yes ○ No ○

Any serious illness or operation in the last three years? ..... Yes ○ No ○

A bad reaction to any medicine or anaesthetic? ..... Yes ○ No ○

Any form of liver disease (e.g. jaundice, hepatitis) or kidney disease? ..... Yes ○ No ○

Epilepsy, fainting attacks, giddiness or blackouts? ..... Yes ○ No ○

Any infectious diseases (including HIV and hepatitis)? ..... Yes ○ No ○

Any stomach problems? ..... Yes ○ No ○

Do you bruise easily or bleed excessively after a cut or tooth extraction? ..... Yes ○ No ○

Have you had any medical prostheses (e.g. hip replacement or heart valve)? ..... Yes ○ No ○

Have you ever had a difficult extraction? ..... Yes ○ No ○

Do you take bisphosphonates (osteoporosis drugs)? ..... Yes ○ No ○

Do you take anti-coagulants (e.g. Warfarin/Clopidogrel)? ..... Yes ○ No ○

Any other medical problem? ..... Yes ○ No ○