Page 1 - Your Personal Dental Assessment

Welcome to Far Headingley Dental Care. For us to ensure that we can provide you with the most appropriate dental care, we kindly ask you to complete the following questions. Any information that you provide is held within strictest confidence at the practice.

Title:________ Name: ____

Home Address: ____

____

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Home Telephone:______________ Mobile:_____________ Work:_____________

Date of Birth: _________________________ Sex: Male ☐ Female ☐

e-mail: _________________________ Occupation:____________________

Dental Insurance: Yes ☐ No ☐ Provider:________________________

Date of last
Dental Examination: ____________ Are you happy with your smile? Yes ☐ No ☐

Would you like your teeth to look whiter or brighter? Yes ☐ No ☐
Do you have sensitive teeth? Yes ☐ No ☐
Do you have any teeth that are unsightly or crooked? Yes ☐ No ☐
Are you concerned about any old crowns that do not match? Yes ☐ No ☐
Do you have any missing teeth that you would like to replace? Yes ☐ No ☐
Would you prefer tooth coloured fillings to replace any silver ones? Yes ☐ No ☐
Do you consider yourself a nervous patient? Yes ☐ No ☐
What (if anything) would you like to change about your teeth?

____

How did you hear about Far Headingley Dental Care?

Recommended by friend or family ☐
Internet – www.fhdc.co.uk ☐
Sign outside building ☐
Advertising ☐
(please state which) _______________
Other ☐
(please list) ______________________

Page 2 - Your Confidential Patient History Form

It is important for us to have up to date medical history for all our patients. Please take the time to complete this form and answer the following questions. Providing this information helps us treat our patients safely. All information provided will be kept strictly confidential.

Doctors Name: ______________________ Doctors Telephone: ______________

Doctors Address: ______________________

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____

Name of previous Dentist: ______________________

Do you have, or have you suffered from any of the following? (Please tick Yes or No)

		Please list medication/other details
Rheumatic Fever	Yes ☐ No ☐	
Any heart condition	Yes ☐ No ☐	
Diabetes	Yes ☐ No ☐	
Epilepsy	Yes ☐ No ☐	
Asthma or Bronchitis	Yes ☐ No ☐	
Liver disease	Yes ☐ No ☐	
Excessive bleeding	Yes ☐ No ☐	
High blood pressure	Yes ☐ No ☐	
Any serious illness	Yes ☐ No ☐	
Any allergies including medicines	Yes ☐ No ☐	
Had any surgical operations	Yes ☐ No ☐	
Bruising or persistent bleeding	Yes ☐ No ☐	
Any infectious diseases including HIV and Hepatitis	Yes ☐ No ☐	

Do you smoke Yes ☐ No ☐ If yes, how many per day? _____

How many units of alcohol do you drink per week? _____
(1 unit =1 glass wine, ½ pint beer or lager or 1 measure of spirit)

Do you chew any form of tobacco? (Betelnut, Paan)? Yes ☐ No ☐

Could all ladies please complete the following section:

Do you take the oral contraceptive pill? Yes ☐ No ☐
Are you pregnant? Yes ☐ No ☐

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

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