Please complete the following:

Full Name and Title	
Date of Birth	
Address	
Home Telephone Work	
Occupation	
Your GP's Name and address	
Previous Dentists Name and address	
Do you consume alcohol? How many units per day/week?	
Do you have bleeding gums?	
Are you worried about bad breath?	.
Are your teeth comfortable?	
Are you happy with the appearance of your teeth?	We can provide cosmetic dentistry including crowns, veneers and white fillings to enhance your appearance.
How did you discover this practice?	
Would you like any information on Dental Technique?	We can also offer you tooth whitening and facial treatments such as Botox/Dermal Filler. Ask your dentist for more information.
Are you apprehensive about treatment ?	
How long ago did you last receive treatment?	

PLEASE HELP US PROVIDE THE BEST CARE POSSIBLE BY COMPLETING THIS CONFIDENTIAL QUESTIONNAIRE AS FULLY AS POSSIBLE. IF YOU HAVE ANY DIFFICULTY, PLEASE ASK ONE OF THE STAFF FOR ASSISTANCE.

Please answer the following	**YES**	**NO**	**Details**
Are you receiving any treatment from your local GP/Hospital/Clinic?			
Are you taking any Medicines/Tablets/Creams/Injections			
Have you taken any steroids within the last two years?			
Are you allergic to any Medicines/Penicillin/Foods?			
Have you had Rheumatic Fever/Chorea/St Vitas Dance?			
Have you had Jaundice/Hepatitis/Kidney or Liver Disease?			
Do you have High Blood Pressure/Angina/Heart Murmur?			
Have you had any recent inoculations or blood tests?			
Has your blood ever been refused by the Blood transfusion service?			
Have you ever suffered a bad reaction to local/ general anaesthetic?			
Are you or might you be pregnant?			
Have you been hospitalized in the last 2 years?			
Do you have Arthritis?			
Have you had Heart surgery or have a Pacemaker?			
|Do you have Hay Fever/Eczema/Asthma?			
Do you suffer from Bronchitis or have Chest Disease?			
Do you suffer from Blackouts//Giddiness/Epilepsy?			
Do you have Diabetes?			
Do you Bruise Easily?			
Do you have a warning card?			
Please advise us of any condition that may be relevant.			
Do You smoke? If Yes – How many a day?			
Please sign & date below			
Dentists signature and date			