Patient Information

Title: Mr / Master / Dr / Mrs / Miss / Ms

Name: ____ Date of Birth: ____/____/______

Your NHS Number: ____

Address: ____ Home Number: _______________________________

____ Mobile Number: _______________________________

____ Work Number: _______________________________

Email Address: ____

Occupation: __________________________________ Country of Birth: ______________________________

How did you hear about Essential Dental? ____

Smile Questionnaire

- When was your last dental visit? (approx. time or date) _______________________________
- How often to you brush your teeth? _______ times day / week

  What type of toothbrush do you use? Manual / Electric
- Do you use any addition cleaning aids (Floss, Tepe brushes, Picks or Mouthwash? **Yes / No**
- If Yes, What do you use and how often?
- Are you happy with the appearance of your teeth? **Yes / No**

We can offer private treatment for cosmetic and preventative procedures for the following treatments, please tick any you may be interested in.

Tooth Whitening ☐	Implants ☐	Other ☐
Veneers ☐	Crowns ☐	_______________________________
Orthodontics ☐	Hygiene Appointments ☐	

Please ask the dentist in surgery about all our cosmetic treatments available.

We also have a monthly payment plan available for children and adults, for 2 hygienist visits per year, plus additional discounts on other private treatments. Please ask a staff member for details.

Please Turn Over for Medical Questions

Medical History and Information

Your GP's Name: ____

Your GP's Address: ____

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Your GP's Contact Number: ____________________________________

Are You:	**Yes**	**No**	**Details**
An expectant mother			
Receiving medical treatment			
Taking any medication			
Taking or have you taken any steroids in the past 2 years			
Allergic to any medicines, foods or materials			
Have you:			
Had Rheumatic Fever or Chorea (St Vitus Dance)			
Had Jaundice, Liver, Kidney Disease or Hepatitis			
Had any heart problems, a heart murmur, angina, high blood pressure or a heart attack			
Ever has a blood donation refused by the Blood Transfusion Service			
Adverse reaction to either a Local or a General Anaesthetic			
Had a joint replacement			
Been hospitalised, if yes, for what and when			
Do you:			
Suffer from arthritis			
Have a pacemaker, or any form of heart surgery			
Suffer from allergic disorders such as hay Fever or Eczema			
Suffer from any Respiratory diseases such as Bronchitis or Asthma			
Have epilepsy, fainting attacks, giddiness or blackouts			
Have diabetes or does anyone in your family			
Bruise easily following a tooth extraction, surgery or injury or do you or your family have any bleeding disorders			
Carry a warning card			
Ever get cold sores			
Any other relevant medical information that the dentist should know about			
Do you smoke, if yes, how many per day/week			
Drink alcohol on a weekly basis, if yes, how many per week (1 unit = 1/2 drink)			
Do you or any close relative suffer from Creutzfeldt-Jakob disease (CJD)			
Have HIV			
Have E coli			
Have MRSA			

Signature: ____ Date: ____________________