50 Chatfield Road, Battersea, London SW11 3UJ
Tel: 020 7585 0066

Personal Assessment and Medical History Form

PRIVATE AND CONFIDENTIAL

Family name .... Date of birth ....

First name .... Mr Mrs Ms Miss

Address...

City... Postcode ....

Home phone no .... Mobile no..

Email address .... Occupation ....

When was the last time you visited a dentist? ....

How did you hear about us: Leaflet ☐ Internet ☐ Walked by ☐ GP ☐

☐ Recommended by...

Dental Questionnaire

- 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 ☐
- Do you get food trapped between your teeth? Yes ☐ No ☐
- Do your gums bleed when you brush your teeth? Yes ☐ No ☐
- What type of tooth brush do you use? soft ☐ medium ☐ hard ☐ electric ☐

I wish to join the practice as a patient. I understand and agree to the following:

- That the agreement by which I will be given dental treatment (my Treatment Plan) is an agreement between the dentist and myself.
- That, under my Treatment Plan, my treatment will have been paid for in total by the last visit.
- That I will be charged a fee of £20 for each 15 minutes of an appointment missed or cancelled without 24 hours notice.

Signature.. Date...

Are you currently	Yes	No	GIVE DETAILS
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers)?			
Allergic to any medication, food or substance? (penicillin, latex)			

Have you:	Yes	No	GIVE DETAILS
Had rheumatic fever or chorea?			
Been told that you have heart problems, angina, blood pressure problems, or stroke?			
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 bruising or persistent bleeding following injury, tooth extraction or surgery?			
A joint replacement or other implant?			
Had arthritis or joint replacement?			

Do you:	Yes	No	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+☐

Doctor's name and address: ....

Signature.. Date...