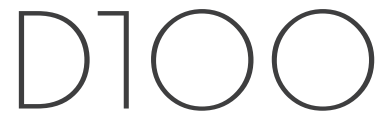


# Medical Form

All information is strictly confidential.



## Personal Details

Title: \_\_\_\_\_

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Home address: \_\_\_\_\_ Postcode: \_\_\_\_\_

Mobile no: \_\_\_\_\_ Phone no: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work phone no: \_\_\_\_\_

Work address: \_\_\_\_\_ Work postcode: \_\_\_\_\_

## Medical Questionnaire

Name and phone number of General Medical doctor: \_\_\_\_\_

Are you receiving any medical treatment from the doctor, hospital or clinic?  Yes  No If yes please give details: \_\_\_\_\_

Are you taking any medication?  Yes  No If yes please give details: \_\_\_\_\_

Are you taking any vitamin supplements?  Yes  No If yes please give details: \_\_\_\_\_

If you have had any of the following conditions please place a tick next to the condition:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Low blood pressure     | <input type="checkbox"/> Bronchitis     |
| <input type="checkbox"/> Heart attack  | <input type="checkbox"/> Replacement heart valve | <input type="checkbox"/> Rheumatic fever        | <input type="checkbox"/> Heart valve    |
| <input type="checkbox"/> Angina        | <input type="checkbox"/> Liver disease           | <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Heart murmur           | <input type="checkbox"/> Epilepsy       |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Hip / knee replacement | <input type="checkbox"/> HIV / Aids     |

Are you pregnant?  Yes  No If yes please give due date: \_\_\_\_\_

Do you take contraceptive pills?  Yes  No

Do you suffer from allergies?  Yes  No If yes please give details: \_\_\_\_\_

Do you smoke?  Yes  No If yes how many per week: \_\_\_\_\_

Do you suffer from depression?  Yes  No

Is there anything else you would like to tell us?  Yes  No If yes please give details: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Periodontal Assessment Questionnaire

The following questionnaire will enable us to develop a treatment plan to maximise your treatment outcome.

All information is strictly confidential.

# D1000

### Please answer the following questions:

When was your last dental hygiene appointment?

---

Do your gums ever bleed?  Yes  No

Are you self-conscious about your breath?  Yes  No

Have you noticed that your gums are receding?  Yes  No

Do you have loose teeth?  Yes  No

Do you have teeth that have changed position?  Yes  No

Are your teeth becoming more sensitive to temperatures or touch?  Yes  No

Are you taking prescribed medication?  Yes  No

Have you been diagnosed with active bacterial gum infection in the past?  Yes  No

Have you ever been diagnosed with periodontal disease?  Yes  No

Do you smoke or use tobacco?  Yes  No

If yes how many per day?

---

Do you drink alcohol?  Yes  No

If yes how many times per week?

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Do you have any known risk of heart disease such as:

High Cholesterol

High blood pressure

Family history of heart disease

Stress

Signature:

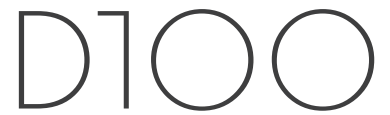
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Date:

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# Smile Profile

All information is strictly confidential.



## Please answer the following questions:

Are you happy with your smile?

Yes  No

What do you like most about your smile?

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What do you like least about your smile?

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How important is your dental health to you?

1  2  3  4  5

1: Not important, 5: Very important

How would you rate your current dental health?

1  2  3  4  5

1: Very poor, 5: Very good

Please tick the following statements you consider to be true:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> I wish the gaps between my teeth were smaller | <input type="checkbox"/> I think my teeth are too large/too small      | <input type="checkbox"/> I don't know what the dentist can do to improve my smile             |
| <input type="checkbox"/> I wish I had a wider smile                    | <input type="checkbox"/> I am unhappy about my smile                   | <input type="checkbox"/> I am concerned that I can not afford the dentistry that I would like |
| <input type="checkbox"/> I wish my teeth were the same colour          | <input type="checkbox"/> I suffer with headache/jaw pain               | <input type="checkbox"/> I dislike the old crowns that do not match the other teeth           |
| <input type="checkbox"/> I wish my teeth were whiter                   | <input type="checkbox"/> I have a click in my jaw                      | <input type="checkbox"/> I dislike the crowns that have black lines around the margins        |
| <input type="checkbox"/> I wish my teeth were straighter               | <input type="checkbox"/> I have discomfort when chewing                |   |
| <input type="checkbox"/> I am worried about the cracks in my teeth     | <input type="checkbox"/> I have fractured teeth in the past            |   |
| <input type="checkbox"/> I do not smile because of my teeth            | <input type="checkbox"/> I am aware of clenching and grinding my teeth |   |
| <input type="checkbox"/> I would like to replace missing teeth         | <input type="checkbox"/> I would like to improve my lines and wrinkles |   |
| <input type="checkbox"/> I think my gums show too much when I smile    | <input type="checkbox"/> I would like to enhance my lips               |   |

What are you hoping to achieve from your dental visit today?

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What are your expectations of us?

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Signature:

Date: