Smile Check

Please tick the relevant boxes to help us know your current dental concerns

LET US HELP YOU TO IMPROVE YOUR MOUTH AND SMILE.....

Are you happy with your smile? Yes/No

q Would you like your teeth to look whiter or brighter?

q Are your teeth sensitive?

q Have you any teeth you think are unsightly, mis-shapen or out of line?

q Do you have any old crowns that now do not match your other teeth or have dark line at the gums?

q Do you have any old or stained fillings that show when you smile?

q Do you have any silver fillings that you would like replacing with tooth coloured mercury free restorations so that they blend in better?

q Do you have any gaps that you would like replacing to improve your smile and your bite?

q Do you have an old, worn denture, or an NHS denture that looks false and feels false?

q Are your teeth stained or your gums red and swollen?

q Do your gums bleed when brushing?

q Do you get a bad taste in your mouth or around some teeth?

q Are you concerned that you may have bad breath?

q If you play contact sport, do you have a custom made gumshield?

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HorsforthSmileClinic

Medical & Dental History

Quality Family Dental Care

Implants

Sedation

Cosmetic Dentistry

Facial Rejuvenation

www.horsforthsmileclinic.co.uk

Personal Dental Assessment

If you are new to the Horsforth Smile Clinic may we offer you a warm welcome. We are delighted that you have selected our practice to provide your dental care. So that we can do our best for you, we would like to ask you a few questions which will take a few minutes to answer.

If you are an existing patient at Horsforth Smile Clinic we constantly aim to improve the service we offer you. Please could you take a few minutes to complete this Personal Dental Assessment and bring it with you to your next visit.

Please tell us:

Your full name .....

.....

Address .....

.....

.....

.....

.....

Post Code .....

Daytime number .....

Mobile Number .....

Email .....

Date of Birth .....

What is your occupation?

.....

What is your doctor's name & telephone number?

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We hope you will be very satisfied with the care you receive in our practice. We would like to know what made you choose us. Were any of the following reasons involved?

q Convenient location
q Recommended by a friend
q Family member already a patient here
q For emergency treatment only
q Referred by another dentist
q Located from yellow pages
q Located yell.com/internet
q Newspaper/magazine
q Another reason, please specify:

.....

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When did you visit your last dentist?

.....

Have you left another practice in order to come here? Yes / No

If you think it is important to explain why, please do so.

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Confidential Medical History

A. ARE YOU

1. Attending or receiving any treatment from a doctor, hospital, clinic or specialist? Yes/No .....
2. Taking any medicines or tablets prescribed by your doctor? Yes/No .....
3. Allergic to penicillin or any other drug or substance or foods (eg latex/rubber)? Yes/No .....
4. Pregnant or had a baby within the last 12 months? Yes.No .....

B. IN THE PAST HAVE YOU

1. Ever had a heart problem, angina, high or low blood pressure, heart attack or stroke? Yes/No .....
2. Ever had rheumatic fever or infective endocarditis Yes/No .....
3. Ever had jaundice, hepatitis, liver problems or kidney disease? Yes/No .....
4. Ever had asthma, bronchitis, hayfever or any serious chest infections? Yes/No .....
5. Ever had any blood related diseases or transfusion? Yes/No .....
6. Ever had a bad reaction to a local or general anaesthetic? Yes/No .....
7. Ever had an operation or received hospital treatment? Yes/No .....
8. Ever had a heart valve replaced ? Yes No .....
9. Had your blood refused by the Blood Transfusion Service? Yes/No .....
10. Had growth hormone treatment before the mid 1980's? Yes/No .....

C. DO YOU

1. Have a pacemaker? Yes/No .....
2. Have fainting attacks, giddiness or epilepsy? Yes/No .....
3. Have diabetes? Yes/No .....
4. Carry a warning card? Yes/No .....
5. Bruise easily or have you ever bled excessively? Yes/No .....
6. Take or have you ever taken steroids? Yes/No .....
7. Do you smoke? Typically how many per day? Yes/No .....
8. Have you a close relative (parent, sibling, grandparent or grandchild) with Creutzfeldt Jakob disease? Yes/No .....
9. Drink alcohol (A unit is half a lager, a single measure spirit or glass of wine? Yes/No How many units per week? .....
10. Suffer from headaches or migraine? Yes/No .....
11. Suffer from Arthritis? Yes/No .....
12. Have any infectious diseases such as HIV, CJD or Hepatitis, if so what? Yes/No .....