Hampton Wick Dental Centre

Personal Dental Assessment

Personal details

Title..... Name ..... Date of birth .....
Address .....
.....
.....Postcode .....
E-mail address .....
Telephone (daytime) ..... Telephone (mobile) .....

Business details

Address .....
.....
.....Postcode .....
E-mail address .....
Telephone (daytime) ..... Telephone (mobile) .....

Dental history

When was your last dental examination? .....
How did your hear about the Hampton Wick Dental Centre? .....
....
Do you have Dental Insurance? .....Yes ☐ No ☐

About you

Are you happy with your smile? .....Yes ☐ No ☐
Would you like your teeth to look whiter or brighter? .....Yes ☐ No ☐
Are your teeth sensitive? .....Yes ☐ No ☐
Do you have any teeth you think are unsightly, misshapen or out of line? .....Yes ☐ No ☐
Are you concerned you may have bad breath or an unpleasant taste in your mouth? .....Yes ☐ No ☐
Do your gums bleed when you brush or floss? .....Yes ☐ No ☐
Do you suffer from headaches, neck aches or shoulder pain? .....Yes ☐ No ☐
Do you clench or grind your teeth? .....Yes ☐ No ☐
Do you smoke ? .....Yes ☐ No ☐
How many a day? .....

Are you concerned about:

Old crowns that do not match your other teeth or have dark lines at the gum? .....Yes ☐ No ☐
Old or stained fillings that show when you smile? .....Yes ☐ No ☐
Silver fillings that you would like to replace with tooth coloured ones? .....Yes ☐ No ☐
Any missing teeth that you would like to replace? .....Yes ☐ No ☐

continued...

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Personal Dental Assessment

continued.

Are you …

Fit and healthy? ..... Yes ☐ No ☐

Receiving treatment from a doctor, hospital or clinic? ..... Yes ☐ No ☐

Taking any pills, medicines or tablets? ..... Yes ☐ No ☐

Allergic or have reacted adversely to:

Penicillin or any other drug or medicine? ..... Yes ☐ No ☐

Latex, rubber or other materials? ..... Yes ☐ No ☐

Costume jewellery or other metals? ..... Yes ☐ No ☐

Taking any of the following:

Antibiotics? ..... Yes ☐ No ☐

Anticoagulants? ..... Yes ☐ No ☐

Medicine for high blood pressure? ..... Yes ☐ No ☐

Cortisone or other steroids? ..... Yes ☐ No ☐

Insulin or other diabetes medication? ..... Yes ☐ No ☐

Tablets for Osteoporosis (biphosphorates)? ..... Yes ☐ No ☐

Other medication ..... Yes ☐ No ☐

In the past, have you …

Had any serious illnesses? ..... Yes ☐ No ☐

Had any of the following diseases or problems:

Rheumatic fever or rheumatic heart disease? ..... Yes ☐ No ☐

Heart trouble, replacement heart valve, high blood pressure or stroke? ..... Yes ☐ No ☐

Sinus trouble? ..... Yes ☐ No ☐

Asthma or respiratory diseases? ..... Yes ☐ No ☐

Diabetes? ..... Yes ☐ No ☐

Hepatitis or HIV? ..... Yes ☐ No ☐

Had abnormal bleeding associated with previous extractions, surgery or trauma? ..... Yes ☐ No ☐

Had any problems with previous dental treatment? ..... Yes ☐ No ☐

Women patients only …

Is there any possibility that you may be pregnant? ..... Yes ☐ No ☐

If so, what is the estimated date of delivery? .....

Final Comments

Is there anything else you would like to tell us? .....

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Signature..... Date.....

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