



MP Dental Practice

s m i l e w i t h c o n f i d e n c e

Medical & Dental History

Full Name:

186 Jamaica Road, Bermondsey, London SE16 4RT

Tel: 020 7231 2883 · 07071 DENTAL

Fax: 020 7237 0058

www.mpdental.co.uk



Personal Dental Assessment

If you are a new patient at MP Dental Practice, 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 provide the best care for you, we would like you to answer a few questions, which will take about 5 minutes to complete.

If you are an existing patient at MP Dental Practice, we constantly aim to improve the service we offer you. Please could you take a few minutes to complete this Personal Dental Assessment.

Please tell us:

Address.....
.....
.....

Postcode.....

Daytime number.....

Evening number

Mobile.....

Date of birth.....

What is your occupation?.....
.....

Do you have any children?

Yes No

Ages if "yes"

If you are currently receiving or have the following? (please tick)

- Disabled Persons Tax Credit (DWA)
- HC2 Certificate
- HC3 Certificate
- Income Support
- Jobseeker's Allowance
- Working Family Tax Credit (Family Credit)

We hope that 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?

- Convenient location
- I was recommended by a friend
- Convenient surgery times
- Family member already a patient here
- For emergency treatment only
- Referred by another dentist
- Located from Yellow Pages
- Located from Thomson Directory
- Internet
- Another reason, please specify

.....
.....

When did you last visit a dentist?.....

Have you left another practice to come here?

Yes No

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

.....
.....



Confidential Medical History



Some medical conditions and medicines used to treat them can effect dental treatment. So that we are able to give you the best and most appropriate treatment possible, we need to know whether you are having any medical treatment or taking pills, medicines or drugs. It will also help if we know of any illness in the past. Please complete the questionnaire below.

	YES	NO	Further Details
ARE YOU			
1. Attending or receiving treatment from a doctor, hospital, clinic or specialist			
2. Taking ANY pills, tablets or medicines.			
3. Pregnant or nursing mother			
4. Allergic to ANY medicines e.g. Penicillin, Aspirin, Local Anaesthetic, Sleeping Pills.			
5. Taking or have taken Steroids in the last 2 years.			
HAVE YOU			
1. Had any serious illness or operation in the last 3 years.			
2. Had Rheumatic fever, Chorea or St Vitus' dance			
3. Had jaundice, liver, kidney disease or hepatitis.			
4. Had heart trouble of any kind e.g. murmurs, birth defects, angina, hypertension.			
5. Ever reacted adversely to a General Anaesthetic.			
6. Please tell the dentist if you are HIV positive or have had your blood refused by the Blood Transfusion Service			
DO YOU/DOES YOUR			
1. Suffer from Headaches / Migraine			
2. Clench and/or grind your teeth.			
3. Jaw click.			
4. Suffer from fainting spells, blackouts or epilepsy			
5. Have abnormal blood pressure, high or low.			
6. Suffer from diabetes.			
7. Have any lung problems or breathing difficulties.			
8. Bruise easily or suffer from excessive bleeding after a cut or tooth extraction.			
9. Have any stomach trouble.			
10. Have any medical prosthesis, hip replacement, artificial heart valve, pacemaker etc.			



Smile Check

- | | Yes | No |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. These days a lot can be done to prevent the need for dental treatment, such as fillings. Would you like to know more about this preventative approach to your own or your children's dental care? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you satisfied with your teeth and their appearance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you self-conscious about your teeth when you smile? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you wish your teeth were a lighter colour? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you wish your teeth were shaped differently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any irregularly positioned teeth, which you dislike? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any discoloured teeth, which embarrass you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do your front teeth have fillings, which do not match the colour of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you wish the fillings in your back teeth were tooth coloured instead of black? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do your gums appear red and swollen and bleed when you brush them? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you suffer from bad breath - halitosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. If you could alter your smile what would you most like to change? | | |
| | | |
| | | |
| | | |

13. On a scale of 1 - 10 how happy are you with your smile? (1 not happy, 10 very happy)

1	2	3	4	5	6	7	8	9	10

14. Does anything concern you about your dental health at the moment?

.....

.....

.....

Having read our Cosmetic Smile File is there any questions you have on the treatments mentioned

.....

.....

Signed:.....

Date:.....

Thank you for taking the time to answer our questions.

Re-Evaluation

Signed.....

Date

Signed.....

Date

Signed.....

Date

Signed.....

Date