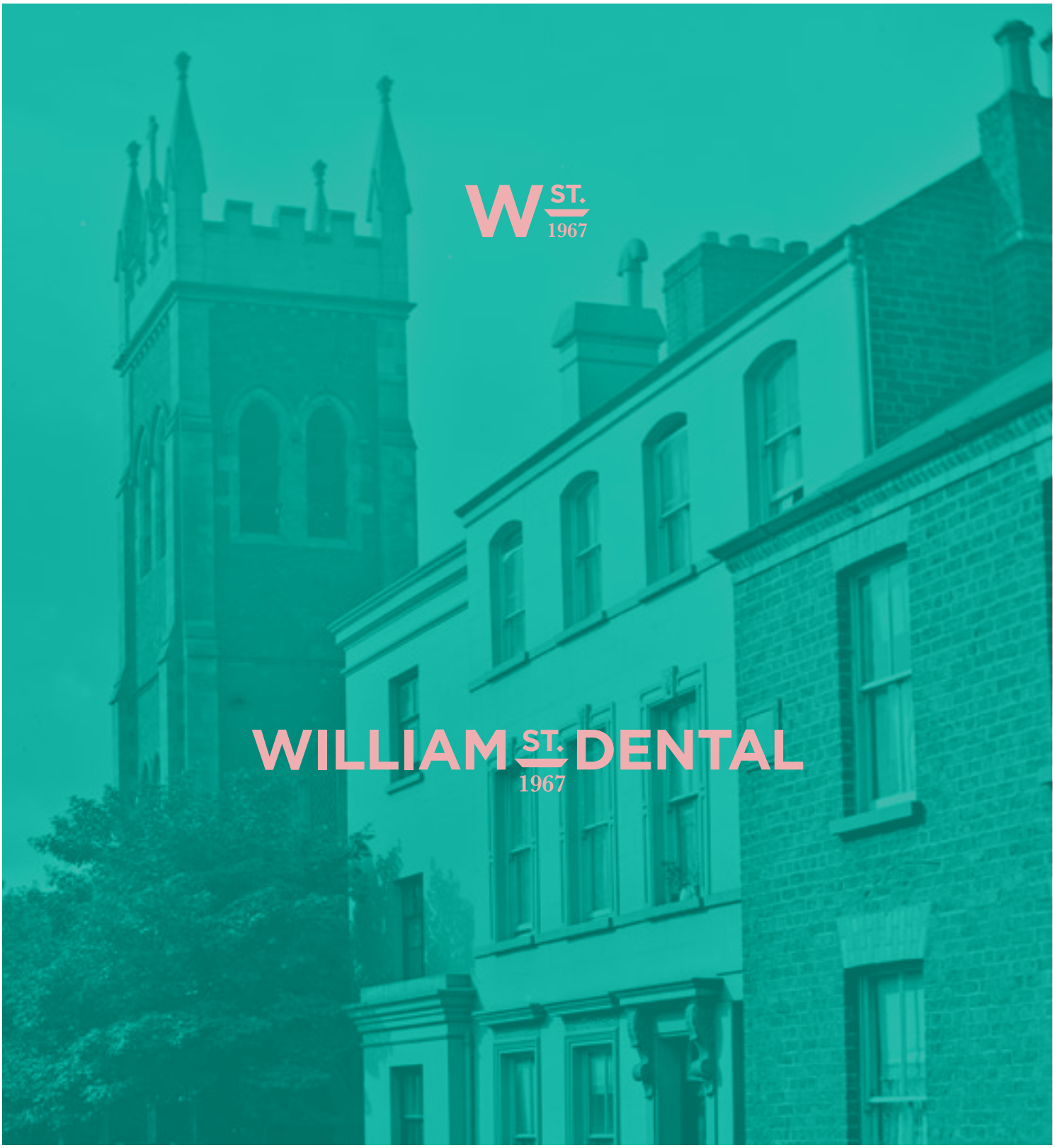

Personal Medical & Dental History

Name

Date of Birth

WILLIAM ST. DENTAL
1967

Confidential Medical History

To offer the best and appropriate dental care we ask that you provide us with as much detail as possible about your medical history.

Please complete all questions & tick the relevant boxes.

Name _____ Mr/Mrs/Ms/Master/Miss/Dr/Other

Address _____

_____ Post Code _____

Phone _____ Mobile _____

E-mail Address _____

☐ **I am happy to receive text messages and emails to the number and email address provided.**

Date Of Birth _____ Occupation _____

School (if relevant) _____

Parent/Guardian Name (if relevant) _____

Doctor's Name _____

Doctor's Address _____

How did you hear about the practice? ☐ Friend/Family ☐ Yellow Pages ☐ Internet/Website

If another please advise _____

Do any of your friends/family that come to William Street Dental for treatment? _____

What is their name so we may thank them? _____

Are You:	**Circle**	**Details**
Receiving treatment from your doctor or hospital?	Yes/No	
Taking any prescribed medication?	Yes/No	
Carrying a medical warning card?	Yes/No	
Pregnant or likely to be so?	Yes/No	

Have you ever suffered from:	**Circle**	**Details**
Allergies to medicines (e.g. Penicillin)?	Yes/No	
Allergies to food/substances (e.g. Latex)?	Yes/No	
Had rheumatic fever?	Yes/No	
Asthma, bronchitis, or any other chest condition?	Yes/No	
Fainting, blackouts or epilepsy?	Yes/No	
Heart problems, blood pressure or stroke?	Yes/No	
Diabetes (or in the family)?	Yes/No	
Bone or joint disease?	Yes/No	
Bruising or persistent bleeding after injury tooth extraction or surgery?	Yes/No	
Liver disease?	Yes/No	
Any other serious illness or infectious disease?	Yes/No	
Blood refused by the blood transfusion service?	Yes/No	
A bad reaction to local anaesthetic?	Yes/No	
Treatment that required you to be in hospital?	Yes/No	

Sugary Foods Do you snack regularly on sugary or acidic foods? _____

Alcohol How many units per week? _____

Smoking Do you or have you smoked in the past? _____

Do you snore or suffer from sleep apnoea? Yes/No _____

Please give us any other information your dentist may need to know such as self-prescribed medicines or disabilities you may have:

_____

_____

When was the last time you saw a dentist? _____

Patient Signature _____ Date _____

Dentist Signature _____ Date _____

WILLIAM ST. DENTAL
1967

Smile Evaluation

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

	Yes	No
Do you have crooked teeth?	☐	☐
Do you have any noticeable spaces between your teeth?	☐	☐
Are you missing any teeth?	☐	☐
Would you like your teeth to look brighter or whiter?	☐	☐
Do you have any old crowns that now do not match other teeth or have dark lines at the gums?	☐	☐
Do you have any old or stained fillings that show when you smile?	☐	☐
Do you have any silver fillings that you prefer were tooth coloured?	☐	☐
Do your gums bleed when brushing?	☐	☐
Are you self conscious about your smile?	☐	☐
Do you find yourself not smiling in photos or covering you teeth with your hands or lips?	☐	☐

Patient Signature _____ Date _____

Patient Signature _____ Date _____

Patient Signature _____ Date _____

Patient Signature _____ Date _____

Patient Signature _____ Date _____

Patient Signature _____ Date _____

Patient Signature _____ Date _____

Patient Signature _____ Date _____

Patient Signature _____ Date _____

Patient Signature _____ Date _____

Patient Signature _____ Date _____