

Smile Analysis

	Yes	No
Do your gums ever bleed?		
Do you have any missing teeth?		
Are you concerned about the appearance of your smile?		
Have you noticed your teeth getting shorter?		
Have you noticed your teeth getting darker?		
Do you like the alignment of your teeth?		
Do you have fillings in your back teeth?		
Are you happy with the colour of your fillings?		
Do you play any contact sport?		
Does your breath have an odour?		
Are you ever sleepy during the day?		
Do you snore at night?		
Are you confident to smile?		
Please rate your smile out of 10 (with 10 being the best)		

Patients Signature:			
Dentists Signature:			
Date:			

Patient History & Information Questionnaire

Title: _____ Full Name: _____ DOB: _____

Address: _____

_____ Postcode : _____

Email: _____

Home Number : _____ Mobile : _____

Work Telephone number: _____ Occupation: _____

Where did you hear about us?: _____

Your GP's Name & Address: _____

Are you interested in saving 10% off future treatment?

Medical History

	Yes	No	Comment
Are you receiving any form of treatment from a doctor, hospital, clinic or specialist?			
Are you taking any medicines, tablets, drugs or injections or using any cream, ointment or inhaler?			
Are you taking or have you taken steroids in the last 2 years			
Are you allergic to any medicine, food or materials			
Do you carry a warning card?			
Are you pregnant or a nursing mothers?			
Have you even been diagnosed with / do you suffer from any of the following? <ul style="list-style-type: none"> • HIV • Rheumatic fever or chorea • Heart condition or murmur or high blood pressure (or fitted with a pacemaker) • Blood disorder • Excessive bleeding/bruising • Bronchitis, asthma or other chest condition • Fainting attacks, giddiness, blackouts or epilepsy • Diabetes • Jaundice, liver or kidney disease • Hepatitis 			
Have you ever had a stroke?			
Have you had a joint replacement or other implant?			
Have you ever had a bad reaction to a local or general anaesthetic?			
Are there any other aspects, concerning your health that your dentist should know about?			
On average, how much of the following do you consume?	Cigarettes (per day)		Alcohol (units per week)

Additional Comments

Jaw Joint & Bite Balance Monitoring Programme Questionnaire

	Yes	No
Have you ever been diagnosed with a problem with either jaw joint?		
Does your jaw joint click, pop or make noise when you open and close?		
Do you have pain or tenderness in your joint when you open, close or chew?		
Has your jaw ever locked open or closed?		
Have you ever had a bite splint or mouth guard made for you?		
Do you have a history of trauma to your chin or jaw, such as a blow to the face or a car accident?		
Do you have headaches, neck or back problems?		
Are you on any medication for pain relief?		
Are you being treated by an osteopath, chiropractor or physical therapist?		
Do you suffer from a movement disorder (tic) or been diagnosed as having Tourette's Syndrome?		
Have you undergone orthodontic treatment?		
Have you ever experienced broken, sensitive or worn teeth?		
Do you or have you been told you clench and/or grind your teeth?		
Do you suffer any pain or headache symptoms? If Yes please indicate location on the chart below.		

