NEW PATIENT APPLICATION FORM

Title		Date of Birth	
First Name			
Surname			

How would you prefer to be addressed?	
Please state	

Address including postcode

Mobile number	
Landline number	
Email address	

We would like to know what made you chose our dental practice?

NHS website ☐ Passing by ☐ Location ☐

NHS Choices ☐ Google ☐

Friend /family- please state name _____

Other please state _____

GP Surgery name and address

NHS Number	
Occupation	

Do you smoke? If so how many a day?	
Do you drink? If so how many units a week?	
When did you last see your dentist?	
Any current dental issues?	

On a scale of 1 -5 how would you rate your smile? 1 - poor - 5 good 1 2 3 4 5

Are you satisfied with your teeth and their appearance or self conscious about your teeth when you smile? Yes ☐ No ☐

Do You?

Wish your teeth were whiter? Yes ☐ No ☐

Wish your teeth were shaped differently ? Yes ☐ No ☐

Have any irregular positioned teeth which you dislike? Yes ☐ No ☐

Do You?	Yes	No
Have any discoloured teeth which embarrass you?	☐	☐
Have fillings that do not match the colour of your teeth?	☐	☐
Wish the fillings in your back teeth were white?	☐	☐
Do you snore?	☐	☐
Have gums that appear red and swollen?	☐	☐
Have gums that bleed when you brush them?	☐	☐
Suffer from bad breath (halitosis) ?	☐	☐

If you could alter your smile , what would most like to change?

_____

Describe your feeling about visiting the dentist? (Please tick)

Relaxed ☐ Anxious ☐ Very Nervous and Anxious ☐

Are there any dental procedures which have frightened you in the past which you are very anxious about? _____

Would you like details of dental care plans available here ? _____

Some medical conditions and medicines used to treat them can affect dental treatment. Please answer ALL questions regarding your health.

Are you?	Yes	No	Details
Are you attending or receiving treatment from a doctor , hospital ,clinic or specialist?			
Taking any pills , tablets or medicine from your doctor? If yes please list			
Taking or have taken any steroids in the last two years?			
Pregnant or a nursing mother?			
Are you allergic to any medicines e.g. Penicillin , aspirin ?			

Signed: _____ Date: _____

Please tick this box if you do wish to be offered any product information from Deu Dental. ☐

PLEASE TURN OVER

CONFIDENTIAL MEDICAL HISTORY

Please answer ALL questions regarding your health.

Have you?	Yes	No	Details
Had rheumatic fever, chorea (St. Vitus' dance)?			
Had jaundice , liver disease , kidney disease or hepatitis?			
Had heart trouble of any kind e.g. Murmurs , birth defects angina or high blood pressure?			
Ever reacted adversely to a general or local anaesthetic			
Had any serious illness or operation inthe last three years?			
Ever had a joint replacement?			
Been hospitalised?			
Ever suffered from arthritis?			
Ever had a pacemaker or heart surgery?			

Do you?	Yes	No	Details
Have any issues relating to depression or mental health?			
Have a latex allergy?			
Suffer from hayfever, eczema or any other allergy?			
Suffer from giddiness, blackouts or epilepsy?			
Suffer from diabetes?			
Suffer from sickle-cell anaemia?			
Bleed easily?			
Carry a warning card?			
Suffer from cold sores?			
Have any other health concerns?			
Use a manual or electric toothbrush? Please state which.			
How many times a day do you brush your teeth?			
Which mouthwash do you use? How many times a day?			
Which toothpaste do you use?			
Clean between your teeth using dental floss, interdental brushes or tape?			
Drink fizzy/diluted drinks or fruit juice? If yes how many a day.			
Have sugar in your tea/coffee? If yes how many a day.			
Is there a family history of tooth decay or gum disease. If so who?			

I can confirm all the information provided is correct to the best of my knowledge. **Signed……** **Date……**

please print **first name** **last name**

PLEASE TURN OVER