Registration Form

Personal Details

Title — Mr I Mrs I Ms I Other : ____________________

Surname — ____________________

First Name(s) — ____________________

Sex — Male I Female

D.O.B. — ____ I ____ I ________ (dd I mm I yyyy)

Address — ____________________

Home telephone — ____________________

Work telephone — ____________________

Mobile telephone — ____________________

Email address — ____________@____________

Occupation — ____________________

Doctors Name — ____________________

Doctors Address — ____________________

Doctors Telephone — ____________________

Dental History

How long since last visit to dentist? — ____________________

Are you anxious about visiting the dentist? — Yes I No

If so, what are you anxious about? — ____________________

Do you brush your teeth twice a day? — Yes I No

Do you use an electric toothbrush? — Yes I No

Do you use interdental cleaning aids? — Yes I No

Do you use a fluoride toothpaste? — Yes I No, If so what one? ____________________

Do you use mouthwash? — Yes I No, If so, what one? ____________________

Are you happy with your smile? — Yes I No, If not, why? ____________________

What would you like you improve? — ____________________

Do you feel you suffer from bad breath? — Yes I No

Would you like whiter teeth? — Yes I No

Would you like straighter teeth? — Yes I No

Would you like to replace any missing teeth? — Yes I No

Would you like to replace any metallic fillings crowns for tooth coloured options? — Yes I No

Are you currently :

Recieving any treatment from a doctor, hospital or clinic?	Yes I No
Taking any medications?	Yes I No (Please list below)
Carrying a medical warning card?	Yes I No
Pregnant, or a nursing mother?	Yes I No

Do you suffer from:

Any allergies? (e.g. penicillin, latex)	Yes I No
Chest conditions? (including asthma, bronchitis, COPD)	Yes I No
Fainting, panic attacks, dizziness or epilepsy?	Yes I No
Heart problems? (including angina, blood pressure, previous heart attack / stroke)	Yes I No
Diabetes? (is there a family history?)	Yes I No
Arthritis? (including osteo, rheumatoid)	Yes I No
Bruising easily, persistent bleeding following injury / extraction / surgery?	Yes I No
Any infectious diseases (including HIV / AIDs, Hep B / C)	Yes I No

Have you ever:

Had any serious operations?	Yes I No (Please list below)
Been treated for any serious illnesses / conditions? (including cancer)	Yes I No
Suffered any liver or kidney disease?	Yes I No
Had any recent blood tests? were they clear?	Yes I No
Bad reaction to conscious sedation, general or local anaesthetic?	Yes I No
Had any heart surgery? (including fitting of a pacemaker)	Yes I No

Social History:

How many units of alcohol do you consume per week? (1 unit = half a pint of lager, a single measure of a spirit, a single glass of wine)	________
Do you smoke?	Yes I No I In past
	________ times per day
Do you chew tabacco / paan?	Yes I No I In past
Do you take recreational drugs ?	Yes I No I In past

Please give any additonal details if you feel there is any information which your dentist would need to know about.

____

____

____

____

____

____