THE LONDON DENTAL STUDIO

Surname:_____Name:_____Mr/Mrs/Miss Date of Birth:_____

Address:_____

Post Code:_____ Occupation:_____

Telephone home: _____ work: _____mobile:_____

Do have any type of private health cover? Medical Y N Dental Y N Which one? _____

SMILE EVALUATION

	Yes	No	Treatment planned Now or Later

1. Do you like the way your teeth look?

Explain:_____

2. Would you like your teeth to be whiter?

3. Would you like your teeth to be straighter?

Explain:_____

4. Would you like to close any spaces between your teeth?

If so, where?_____

5. Would you like your teeth to be longer?

Which ones?:_____

6. Do you like the shape of your teeth?

Explain:_____

7. Would you like to replace any missing teeth?

Explain:_____

8. Would like to replace your silver fillings with tooth-coloured ones?

9. If you could change anything about your smile, what would you?_____

_____

PLEASE TELL US HOW YOU HEARD ABOUT US

Yellow Pages **Thompson Local** **Other directories** **Websearch** **HR/health insurance**

Mini-implant leaflet **A5 Flyer** **Health Authority/ Doctor** **Family/Friend** **Our Website**

Further details_____

_____

P.T.O.

CONFIDENTIAL MEDICAL HISTORY FORM

Please complete this form fully so the dentist knows of any conditions that may affect your dental treatment.

Approximate time since last dental visit:_____ Where? _____

GP's Name: _____

GP's Address:_____

Please delete or specify or circle as applicable

ARE YOU **YES NO**

Attending or receiving treatment from Dr., Hospital, Clinic or Specialist

Taking any medicines from your Dr. (tablets, creams etc)

Taking or have taken steroids in the last two years?

Allergic to any medicines, foods or materials? **_____**

Pregnant or a Nursing mother please give due/birth date

HAVE YOU

Had Rheumatic Fever or Chorea (St.Vitus Dance)

Jaundice, liver, kidney disease or Hepatitis

Ever been told you have a heart murmur or heart problem

Angina, blood pressure or had a heart attack

Had any blood tests, inoculations etc – routine / other

Ever had your blood refused by the blood transfusion service

Ever had a bad reaction to local or general anaesthetic

Hip or other joint replacement

Been hospitalised. If YES when and what for?_____

DO YOU:

Have arthritis

Have a pacemaker, or have you had any form of heart surgery

Suffer from hayfever, eczema or other allergy

Suffer from bronchitis, asthma or other chest condition

Have fainting attacks, giddiness, blackouts or epilepsy

Have diabetes or does anyone in your family

Bruise easily, following a tooth extraction, surgery or injury

Have you or your family bled so as to cause you to be worried

Carry a warning card if yes for what reason

Ever get cold sores

Do you smoke? Approx amount daily ( ) Alcohol consumption – UNITS PER WEEK ( )

Dentists believe that for the sake of your general and dental health you should not smoke

THIS FORM HAS BEEN COMPLETED BY SELF / GUARDIAN (delete as appropriate)

Signed:_____ **Date:_____**

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For internal use only

Checked by (dental surgeon): _____Date_____