



DENTAL PERFECTION

PRE-REGISTRATION PACK



PERSONAL DENTAL ASSESSMENT

If you are a new patient at Dental Perfection, may we offer you a warm welcome. We are delighted that you have selected our practice to provide your dental care. In order for us to offer the level of service you deserve, we would like to ask you to fill in this questionnaire and bring it to your first appointment.

If you are an existing patient at Dental Perfection, we constantly aim to improve the service we offer you. Please could you take a few minutes to complete this questionnaire and bring it with you on your next visit.

PLEASE TELL US:

Your full name:

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Address:

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.....

Email:

National Insurance Number:

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Post Code:

Home Number:

Mobile Number:

Date of Birth:

Your Occupation:

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Name and address of your doctor

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.....

Are you a member
of a dental plan?

Yes No

Do you claim any
benefits?

We hope you will be very satisfied with the care you receive in our practice. We would like to know what made you choose us. Were any of the following reasons involved?

- Convenient Location
- I was recommended by a friend
- Family member already a patient here
- For emergency treatment only
- Located from website
- Located from Yellow Pages
- Another reason, please specify

When did you last visit your dentist?

Have you left another practice in order to come here? Yes No

If you think it is important to explain why, please do so

What are your reasons for attending here today?

Are you worried/anxious about seeing the dentist? Yes No

Are you concerned about the finances required?

Yes No

CONFIDENTIAL MEDICAL HISTORY

Certain medical conditions can affect dental treatment and vice versa. Please complete this form by ticking the appropriate boxes and answering ALL the questions. All details will be strictly confidential

Do you have or have you ever suffered from:

	Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy, blackouts, giddiness or fainting <small>(PLEASE CIRCLE ONE)</small>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis, Asthma or any other Respiratory Disease <small>(PLEASE CIRCLE ONE)</small>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, Jaundice, Liver or Kidney Disease <small>(PLEASE CIRCLE ONE)</small>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure or Angina	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease, Heart Attack or any related complaints	<input type="checkbox"/>	<input type="checkbox"/>
Has had Heart/Pace-maker surgery	<input type="checkbox"/>	<input type="checkbox"/>
Steroid Therapy has been administered in past two years	<input type="checkbox"/>	<input type="checkbox"/>
Persistent mouth ulcer lasting more than 3 weeks	<input type="checkbox"/>	<input type="checkbox"/>
HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
Any Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Ever had allergic reactions to Local or General Anaesthetic	<input type="checkbox"/>	<input type="checkbox"/>
Recently undergone any blood tests	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding and/or bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant or have had a baby in the last 12 months <small>delete as appropriate</small>	<input type="checkbox"/>	<input type="checkbox"/>
Undergone a joint replacement operation	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently undergoing any Medical Treatment	<input type="checkbox"/>	<input type="checkbox"/>
At present undertaking medication <small>(PLEASE LIST BELOW)</small>	<input type="checkbox"/>	<input type="checkbox"/>
Undergone hospitalisation that may affect dental care	<input type="checkbox"/>	<input type="checkbox"/>
Any other serious illness or related medical condition	<input type="checkbox"/>	<input type="checkbox"/>
If you smoke, how many per day	<input type="checkbox"/>	<input type="checkbox"/>
What is average weekly consumption of alcohol	<input type="checkbox"/>	<input type="checkbox"/>

Please list any medication you are taking:

If you are not sure of any of the questions, or if your medical circumstances change, please inform the Dentist.

Patient's Signature:

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Date: