# 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 exisiting 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: .....

.....

Post Code: .....

Home Number: .....

Mobile Number: .....

Date of Birth: .....

Your Occupation: .....

.....

Name and address of your doctor

.....

.....

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

**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: .....