

## LET US HELP YOU TO IMPROVE YOUR MOUTH AND SMILE

Please tick the relevant boxes to help us know your current dental concerns.

- Would you like your teeth to look whiter or brighter? .....
- Are your teeth sensitive? .....
- Have you any teeth you think are unsightly, mis-shaped or out of line?  
.....
- Do you have any gold crowns that do not match your other teeth or have dark lines at the gums? .....
- Do you have any old or stained fillings that show when you smile? .....
- Do you have any silver fillings that you would like replacing with tooth coloured mercury free restorations so that they blend in better? .....
- Do you have any missing teeth that you would like replacing to improve your smile and your bite? .....
- Do you have an old, worn denture, or denture that looks and feels false?  
.....
- Are your teeth stained or your gums red and swollen? .....
- Do your gums bleed when brushing? .....
- Do you get a bad taste in your mouth or around some teeth? .....
- Are you concerned that you may have bad breath? .....
- Do you play contact sports without wearing a gum shield to protect your teeth, smile and your bite? .....



TG's Dental Suite  
69 High Street  
Higham Ferrers  
Northamptonshire  
NN10 8DD  
Tel: 01933 318481

[www.tgsdental.co.uk](http://www.tgsdental.co.uk)



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If you are a new patient at **TG's Dental Suite** may we offer you a warm welcome. We are delighted that you have selected our practice to provide your dental care. So that we can do our best for you, we would like to ask a few questions which will take about five minutes to answer.

If you are an existing patient at **TG's Dental Suite** we constantly aim to improve the services we offer you. Please could you take a few minutes to complete this personal Dental Assessment and bring with you to your next visit.

### PLEASE TELL US

Title: .....

Full Name: .....

Address: .....

Postcode: .....

Daytime number: .....

Mobile number: .....

Evening number: .....

Email: .....

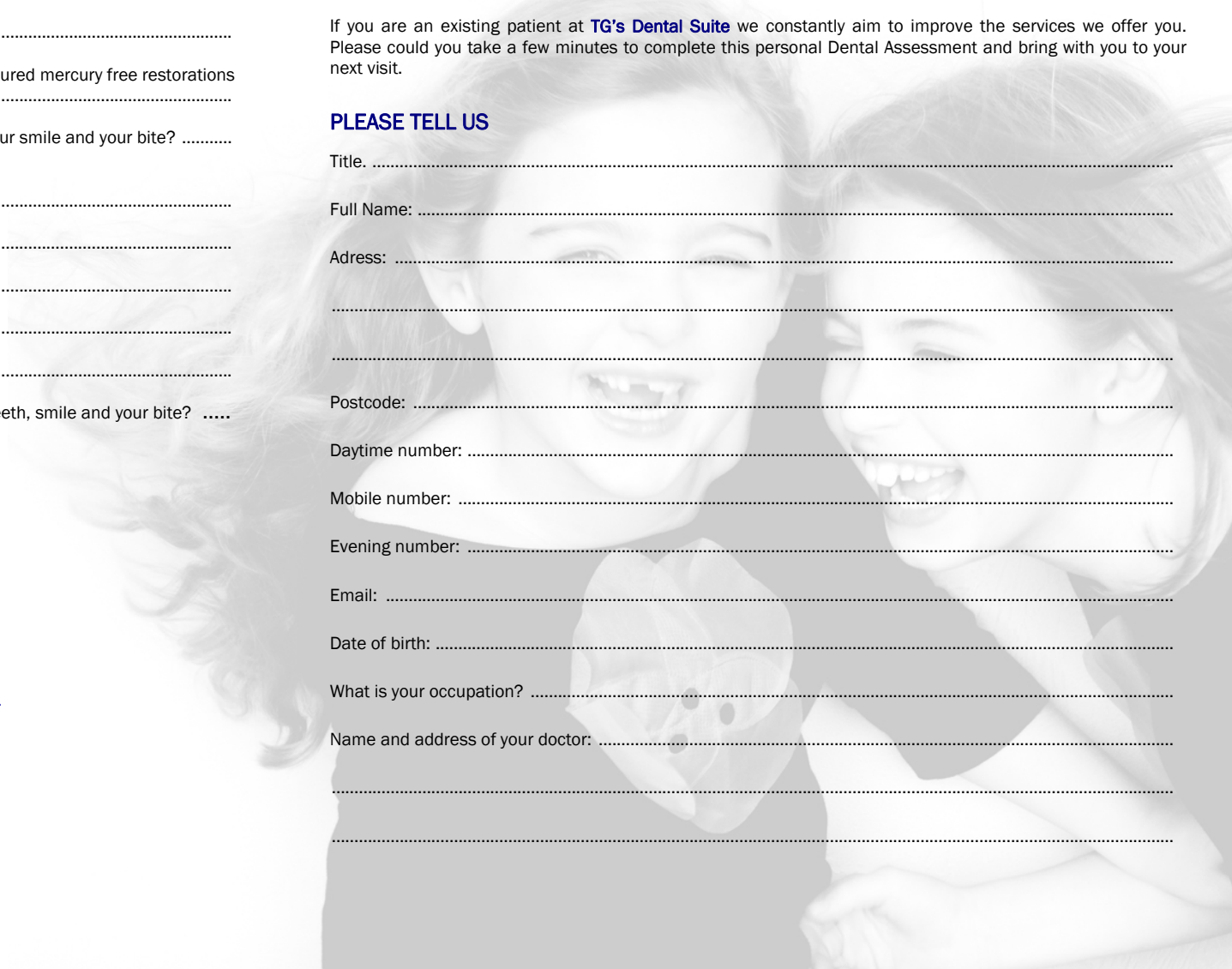
Date of birth: .....

What is your occupation? .....

Name and address of your doctor: .....

.....

.....



## THANK YOU FOR CHOOSING US

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
- Convenient surgery hours
- Family member already patient here
- For emergency treatment only
- Referred by another dentist
- Located from yellow pages
- Located from the internet
- Another reason, please specify .....

When did you last visit your dentist?

.....

Have you left another practice to come here?

- Yes  No

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

.....  
.....  
.....

## ARE YOU?

1. Attending or receiving any treatment from your doctor, hospital, clinic or specialist?  
 Yes  No
2. Taking any medicines or tablets prescribed by your doctor? PLEASE LIST OR ATTACH COPY  
 Yes  No
3. Allergic to penicillin or any other drug or substance or foods (eg latex/rubber/nickel)?  
 Yes  No
4. Pregnant or likely to be so?  
 Yes  No

## IN THE PAST HAVE YOU?

5. Ever had a heart problem, angina, high or low blood pressure, heart attack or stroke?  
 Yes  No
6. Ever had rheumatic fever or heart murmur?  
 Yes  No
7. Ever had jaundice, hepatitis, liver problems or kidney disease?  
 Yes  No
8. Ever had asthma, bronchitis, hayfever or any serious chest infections?  
 Yes  No
9. Ever had any blood related diseases?  
 Yes  No
10. Ever had a bad reaction to a local or general anaesthetic?  
 Yes  No
11. Ever had an operation or received hospital treatment?  
 Yes  No
12. Ever had a heart valve replaced?  
 Yes  No
13. Had a blood transfusion from the Blood Transfusion Service?  
 Yes  No
14. Had growth hormone treatment before the mid 1980's?  
 Yes  No

## DO YOU?

15. Have a pacemaker?  
 Yes  No
16. Have a problem with snoring?  
 Yes  No
17. Have fainting attacks, giddiness or epilepsy?  
 Yes  No
18. Have diabetes?  
 Yes  No
19. Carry a warning card?  
 Yes  No
20. Bruise easily or have you ever bled excessively?  
 Yes  No
21. take or have you ever taken steroids?  
 Yes  No
22. Suffer from arthritis?  
 Yes  No
23. Have a close relative (parent, sibling, grandparent or grandchild) with Creutzfeldt Jakob disease?  
 Yes  No
24. Smoke?  
 Yes  No  
Typically how many per day? .....
25. Drink alcohol?  
 Yes  No  
How many units per week? .....  
(A unit is half a lager, a single measure spirit or a glass of wine)
26. Suffer from headaches or migraine?  
 Yes  No
27. Have any infectious disease such as HIV, CJD or Hepatitis?  
 Yes  No  
If yes, please specify: .....

Completed by Patient or Parent/Guardian

Signature: ..... Date: .....