

Surname: Mr / Mrs / Miss / Master _____

Forename/s: _____

Date of Birth: _____ MALE / FEMALE (please circle)

Permanent Address: _____

Postcode: _____

Home Telephone: _____ Work Telephone: _____

Mobile Phone: _____ E-mail Address: _____

Occupation: _____

Date of last dental treatment (if known, your previous dental practice) _____

Doctor's Name & Address (GP) _____

Where did you hear about us: Family & Friends Leaflet Yellow Pages Outside Sign Web Other

If other, please describe: _____

Preferred day for appointment: Monday Tuesday Wednesday Thursday Friday Saturday

Preferred time: 7am 8am 9am 10am 11am 12am 1pm 2pm 3pm 4pm 5pm 6pm

ARE YOU CURRENTLY:	YES	NO	IF YES, PLEASE GIVE DETAILS
Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Receiving treatment from a doctor, hospital or clinic?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Taking any prescribed medicines (eg tablets, ointments, injections, inhalers including contraceptives or hormone replacement therapy)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Carrying a warning card?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Taking or taken steroids in the last two years?	<input type="checkbox"/>	<input type="checkbox"/>	_____

DO YOU SUFFER FROM:	YES	NO	IF YES, PLEASE GIVE DETAILS
Allergies to any medicines (eg antibiotics), substances (eg latex / rubber) or foods?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay fever or eczema?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fainting attacks, giddiness, blackouts or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have diabetes, or does anyone in your family?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bruising or persistent bleeding following injury, tooth extraction or surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any infectious disease (including HIV or hepatitis)?	<input type="checkbox"/>	<input type="checkbox"/>	_____

DID YOU, AS A CHILD OR SINCE, HAVE	YES NO	IF YES, PLEASE GIVE DETAILS
Rheumatic fever or chorea (St Vitus Dance)?	<input type="checkbox"/> <input type="checkbox"/>	_____
Liver disease (eg jaundice, hepatitis) or kidney disease?	<input type="checkbox"/> <input type="checkbox"/>	_____
Any other serious illness?	<input type="checkbox"/> <input type="checkbox"/>	_____

DID YOU, AS A CHILD OR SINCE, HAVE	YES NO	IF YES, PLEASE GIVE DETAILS
Blood refused by the Blood transfusion Service?	<input type="checkbox"/> <input type="checkbox"/>	_____
A bad reaction to general or local anaesthetic?	<input type="checkbox"/> <input type="checkbox"/>	_____
A joint replacement or other implant?	<input type="checkbox"/> <input type="checkbox"/>	_____
Treatment that required you to be in hospital?	<input type="checkbox"/> <input type="checkbox"/>	_____
Ever been told you have a heart murmur or heart problem, angina, blood pressure problem or heart attack?	<input type="checkbox"/> <input type="checkbox"/>	_____
Brain surgery?	<input type="checkbox"/> <input type="checkbox"/>	_____
Growth hormone treatment before the mid 1980s?	<input type="checkbox"/> <input type="checkbox"/>	_____
A close relative (parents, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob Disease?	<input type="checkbox"/> <input type="checkbox"/>	_____

DRINKING, SMOKING AND CHEWING	YES NO	GIVE DETAILS
Do you drink alcohol? How many units of alcohol do you drink per week? (A unit is half a pint of lager, a single measure of spirits or a single glass of wine/aperitif)	<input type="checkbox"/> <input type="checkbox"/>	_____
Do you smoke any tobacco products now or did you in the past?	<input type="checkbox"/> <input type="checkbox"/>	_____
Do you chew tobacco, pan or supari now or did you in the past?	<input type="checkbox"/> <input type="checkbox"/>	_____

DENTAL QUESTIONNAIRE	YES NO	YES NO
Would you like to improve the look of your smile?	<input type="checkbox"/> <input type="checkbox"/>	Are you concerned with crooked or crowded teeth? <input type="checkbox"/> <input type="checkbox"/>
Would you like to have whiter teeth?	<input type="checkbox"/> <input type="checkbox"/>	Do you get food trapped between your teeth? <input type="checkbox"/> <input type="checkbox"/>
Do your gums bleed when you brush your teeth?	<input type="checkbox"/> <input type="checkbox"/>	Do you have concerns about your breath? <input type="checkbox"/> <input type="checkbox"/>

PLEASE GIVE ANY OTHER DETAILS WHICH YOUR DENTIST MIGHT NEED TO KNOW ABOUT, SUCH AS SELF-PRESCRIBED MEDICINES (EG. ASPIRIN)

I wish to register as a patient with a Dentist at Bluebell Dental Practice, I understand and agree to the following:

- That, under my treatment plan, my treatment will have been paid for in total on completion of treatment,
- That, under my treatment plan, I may be required to pay in advance for certain items of treatment,
- That, I may be charged a fee for an appointment missed or cancelled without 24 hours prior notice,

Completed by: SELF / PARENT / GUARDIAN (please circle)

Signature: _____ Date: _____

MEDICAL HISTORY UPDATE: Have there been any changes in your health, medicines, injections or tablets since your last course of treatment?

Signature: _____ Signature: _____ Signature: _____ Signature: _____

Date: _____ Date: _____ Date: _____ Date: _____