Cathedral Dental Centre

Cathedral Dental Centre

Patient Questionnaire (Confidential)

Name: Mr/Mrs/Miss/Ms/Dr

Surname _____ First names_____

Date of Birth _____/_____/_____ dd/mm/yy Occupation_____

Address home _____ work _____

_____ _____

_____ _____

_____ _____

TICK PREFERRED CONTACT NUMBER

Phone _____◯ Phone _____◯

Mobile _____◯ Mobile _____◯

Email _____◯

Send reminder texts to mobile YES ◯ NO ◯

Name of your doctor/GP _____

How did you hear of this practice?_____ Dental insurance cover? YES ◯ NO ◯

Previous dentist _____ Last visit to a dentist? _____

In case of an Emergency, we should notify:

Name _____ Relationship_____

Phone _____ Mobile _____

If you are under 16 years, please give name, address and phone number of parent/guardian:

Name:

Address:

Phone number:

_____.

Do you prefer:

◯ Amalgam (silver) fillings ◯ Composite (white, non-metal) fillings, if suitable

◯ No preference, guided by dentist ◯ I wish to discuss with the dentist

_____

Blood testing. Although rare, accidental injury to staff can occur during handling of instruments used on you. If this happens, our practice requests both patient and staff member undertake blood testing. Do you agree to confidential blood testing?

YES ◯ NO ◯ I wish to discuss this with your dentist. ◯

Cathedral Dental Centre

Patient Questionnaire continued (Confidential)

1. ALLERGIES
Are you sensitive or allergic to any medicines, foods, LATEX or over the counter or herbal medicines?
If yes, please state:

2. MEDICAL ALERT Do you carry a Medic-Alert card or bracelet? ◯ YES ◯ NO

3. Anaesthetics Have you had an unfavourable reaction to anaesthetics? ◯ YES ◯ NO

4. Artificial or prosthetic joint or heart valve? ◯ YES ◯ NO

5. Bleeding
Had excessive bleeding/ bruising from dental treatment, or other procedures? ◯ YES ◯ NO

6. Smoker ◯ Yes ◯ NO

7. Medications - are you on anything? ◯ YES ◯ NO
If yes, please list (including alternative therapies) or provide a copy of from your pharmacy.

8. Have you had any of the following?

Heart problems	◯ YES	◯ NO	Heart murmurs	◯ YES	◯ NO
Heart surgery /stent (s)	◯ YES	◯ NO	High Blood Pressure	◯ YES	◯ NO
Stroke	◯ YES	◯ NO	Rheumatic fever	◯ YES	◯ NO
Tuberculosis	◯ YES	◯ NO	Hepatitis B or C	◯ YES	◯ NO
Diabetes	◯ YES	◯ NO	Epilepsy /Fits / Seizures	◯ YES	◯ NO
Asthma	◯ YES	◯ NO	Chest & lung disease	◯ YES	◯ NO
Sinus / Hay fever	◯ YES	◯ NO	Kidney problems	◯ YES	◯ NO
Gastric problems	◯ YES	◯ NO	Depressive illness	◯ YES	◯ NO
HIV/AIDS	◯ YES	◯ NO	Radiotherapy	◯ YES	◯ NO

9. Are you under treatment for a medical condition(s) not mentioned in above? ◯ YES ◯ NO
If yes, what is the condition (s)?

10. Females - Are you pregnant? If yes, how many weeks? _____ ◯ YES ◯ NO

11. Are there any other health matters you need to talk to your dentist about? ◯ YES ◯ NO

I confirm that the information written above is true and correct to the best of my knowledge
• I also understand it is very important to report changes or updates in my medical/dental status.

I give permission to obtain from my doctor/GP any additional information regarding my medical history that is needed to provide me with the best and safest dental treatment possible.

Signed by: Patient/Parent/Guardian _____ Date: _____

Cathedral Dental Centre

Cathedral Dental Centre

DENTAL Health Questionnaire

NAME: Date:

1. Do you prefer:

◯ Amalgam (silver) fillings
◯ Composite (white, non-metal) fillings, if suitable
◯ No preference, guided by dentist
◯ I wish to discuss with the dentist

2. *Dental history*

Are your teeth sensitive to hot and cold?	◯ YES	◯ NO
Are your teeth sensitive to sweets or pressure?	◯ YES	◯ NO
Are your teeth painful when you bite?	◯ YES	◯ NO
Are there areas where food gets trapped?	◯ YES	◯ NO
Have you noticed an unpleasant taste?	◯ YES	◯ NO
Do you have loose teeth?	◯ YES	◯ NO
Do you have missing teeth that you would like to replace?	◯ YES	◯ NO

3. *Gum (gingiva) Health*

Do your gums bleed when you brush?	◯ YES	◯ NO
Do you get told you have bad breath?	◯ YES	◯ NO
Do you have a dry mouth?	◯ YES	◯ NO
Do you get a burning sensation in your mouth?	◯ YES	◯ NO
Have you noticed any lumps or sores in your mouth?	◯ YES	◯ NO
Do you use dental floss or interdental cleaning aids?	◯ YES	◯ NO
Do you see a dental hygienist?	◯ YES	◯ NO

4. *Jaw Health*

Does your jaw click, crack, pop or get sore?	◯ YES	◯ NO
Do you grind, squeeze or clench your teeth?	◯ YES	◯ NO
Do you suffer with headaches or migraines	◯ YES	◯ NO

5. *Cosmetic*

Are you happy with your smile?	◯ YES	◯ NO
Is there a part of your smile you would like to change?	◯ YES	◯ NO
Are you satisfied with the colour of your teeth?	◯ YES	◯ NO
Are you happy with the spacing/alignment of your teeth?	◯ YES	◯ NO
Do you have unsightly fillings you would like to change?	◯ YES	◯ NO

6. Any other dental concerns?	◯ YES	◯ NO