

WELCOME TO BRAMPTON DENTAL PRACTICE. 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 you a few questions which will only take a few minutes to answer.

1. Full Name:.....
2. What is your occupation?
3. Do you have any children? YES/NO Age(s).....
4. Which of the following statements best describes your feelings about visiting the dentist?
(Please circle the appropriate letter);
 - A. relaxed
 - B. a little nervous
 - C. very nervous
5. Have you had any dental procedures which have frightened you in the past? YES/NO
6. Does anything concern you about your dental health at the moment
7. Currently does anything concern you about the appearance of your teeth
8. 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? (please circle).
 - A. If you were recommended to the practice please could you provide their name
 (friend, family, professional person).....
 - B. it is near my home/work
 - C. telephone directory
 - D. any other reason?
9. Do any other members of your family visit our practice? YES/NO
10. Have you left another practice in order to come here? YES/NO If you think it is important to tell us why, please do so
11. Which of the following methods of payment would be best for you? (Please circle)
 - A. Paying a deposit on my first visit and follow-up payments when I next attend.
 - B. Set regular monthly payments.
 - C. Payments of all my charges on my first visit.
12. Do you have, or wish to find out about, low cost private dental care plan?
 - A. I have a private dental care plan
 - B. I would like to find out about a private dental care plan.

PATIENT MEDICAL HISTORY FORM

NAME:	
DATE OF BIRTH:	SEX: MALE/FEMALE
ADDRESS:	
	POSTCODE:
TEL NO. HOME:	WORK/MOBILE:
EMERGENCY CONTACT NAME AND TEL NO:	
OCCUPATION:	HOW LONG SINCE LAST DENTAL TREATMENT:
YOUR DOCTORS NAME AND ADDRESS:	

ARE YOU:	YES	NO	DETAILS
An Expectant mother?			
Receiving medical treatment?			
Taking any medication?			
Taking or have you taken steroids in the past 2 years?			
Allergic to any medicines, foods or materials?			
HAVE YOU:			
Had rheumatic fever or chorea? (St Vitus Dance)			
Had jaundice, liver, kidney disease or hepatitis?			
Had any heart problems, a heart murmur, angina, high blood pressure, or a heart attack?			
Had any blood tests, inoculations, etc?			
Ever had a blood donation refused by the Blood Transfusion Service?			
Adverse reaction to either a local or general anaesthetic?			
Had a joint replacement?			
Been hospitalised? "YES" what for and when			
DO YOU:			
Suffer from arthritis?			
Have a pacemaker, or had any form of heart surgery?			
Suffer from allergic disorders such as Hay Fever or Eczema?			
Suffer from any respiratory disease such as Bronchitis or Asthma?			
Have epilepsy, fainting attacks, giddiness or blackouts?			
Have diabetes or does anyone in your family?			
Bruise easily following a tooth extraction, surgery or injury or do you or your family have bleeding disorders?			
Carry a warning card?			
Ever get cold sores?			
Any other relevant medical information that the dentist should know about?			
Do you smoke?			
Do you or any close relative suffer from CJD?			

SIGNATURE AND DATE: