NHS No:

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Maple Dental Surgery

238 Roehampton Lane, London SW15 4LE
Tel: 020 8788 3133, Fax: 020 8785 7605
Personal Assessment and Medical History Form
PRIVATE AND CONFIDENTIAL

MAPLE DENTAL SURGERY

First name ..... Date of birth.....
Surname ..... Mr ☐ Mrs ☐ Ms ☐ Miss ☐
Address.....
..... Postcode.....
Home phone no ..... Mobile no. .....
Email address..... Occupation.....
Your doctor's name and address:
.....
When was the last time you visited a dentist? .....
How did you hear about us: Leaflet ☐ Internet ☐ Walked by ☐ GP ☐ Recommended by .....

Dental Questionnaire

- Do you have any concern about your breath? Yes ☐ No ☐
- Would you like to have whiter teeth? Yes ☐ No ☐
- Would you like to improve the look of your smile? Yes ☐ No ☐
- Do your gums bleed when you brush your teeth Yes ☐ No ☐
- What type of tooth brush do you use? Soft ☐ Medium ☐ Hard ☐ Electric ☐

I wish to join the practice as a patient. I understand and agree to the following:

- That I pay for my treatment by each visit.
- That I may be charged for any appointment missed or cancelled without 24 hours notice.

Signature..... Date.....

Are you currently:	**Yes**	**No**	**GIVE DETAILS**
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers)?			
Allergic to any medication, food or substance? (penicillin, latex)			

Have you:	**Yes**	**No**	**GIVE DETAILS**
Had rheumatic fever or chorea?			
Been told that you have heart problems, angina, blood pressure problems or stroke?			
Had liver disease (e.g. jaundice, hepatitis) or kidney disease?			
A bad reaction to general or local anaesthetic?			
Had your blood refused by the Blood Transfusion Service?			
Had bruising or persistent bleeding following injury, tooth extraction or surgery?			
A joint replacement or other implant?			
Had arthritis?			

Do you?	**Yes**	**No**	**GIVE DETAILS**
Have a pacemaker or have had any heart surgery?			
Suffer from bronchitis, asthma or other chest conditions?			
Have diabetes?			
Suffer from hay fever or eczema?			
Any infectious diseases (including HIV or hepatitis)?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Carry a warning card?			
Any other serious illnesses?			

Are there any other aspects concerning your health that you think the dentist should know about?
Are you, or do you think you may be pregnant? Yes ☐ No ☐ Due on: .....
Do you smoke? If so how many cigarettes a day? No ☐ 1-10 ☐ 11-30 ☐ 30+ ☐
Do you drink alcohol? Never ☐ Occasionally ☐ Regularly ☐

Signature..... Date .....