Full name _____ DOB _____

Dental Information

1 Where was your last practice? _____

2 How long ago was your last appointment (*approximate date*):

Exam: _____ Hygienist:_____ Treatment _____

	Low									*High*
On a scale of 1-10 how important is it for you to keep your teeth?	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
On the same scale how do you rate your dental health today?	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

(please tick)

Do you have any problems with your teeth at present?	Yes	☐	No	☐
Do you have any pain in your teeth?	Yes	☐	No	☐
Do you have any chipped teeth, decay or broken teeth that need attention?	Yes	☐	No	☐
Are any of your teeth sensitive to hot or cold?	Yes	☐	No	☐
Do you have any clicking noises or pain in your jaw joints?	Yes	☐	No	☐
Do you sometimes suffer from bad breath or have bleeding or swollen gums?	Yes	☐	No	☐
Are you unhappy with the appearance of your teeth?	Yes	☐	No	☐
Are you unhappy with the appearance of any silver fillings?	Yes	☐	No	☐
Would you like whiter teeth?	Yes	☐	No	☐
Have you any missing teeth?	Yes	☐	No	☐
Do you clench or grind your teeth?	Yes	☐	No	☐
Do you suffer from headaches?	Yes	☐	No	☐
Do you snore, or have Sleep Apnoea?	Yes	☐	No	☐
Are you anxious about receiving dental treatment / visiting the practice?	Yes	☐	No	☐
If yes, would you like to speak to a member of our non-clinical staff about this?	Yes	☐	No	☐
Would you like to discuss **interest free credit** to help you spread treatment costs?	Yes	☐	No	☐
Is there anything else about your teeth you would like to discuss?	Yes	☐	No	☐

If yes, please give details _____

Are you in any private medical scheme that allows full/part refund of dental charges?	Yes	☐	No	☐

Which scheme are you a member of? _____