ANGEL SMILE DENTAL CARE

GENERAL & COSMETIC DENTISTRY, IMPLANTS, ORTHODONTICS, FACIAL REJUVENATION

1st Floor, 41 Islington High Street, N1 9LH, London

Personal Assessment and Medical History Form

PRIVATE AND CONFIDENTIAL

First name …… Family name ……

Date of birth …… Mr Mrs Ms Miss Occupation……

Email address……

Address……City…… Postcode……

Mobile no …… Home phone no……

Last visited a dentist date ……

How did you hear about us: Internet ☐ Walked by ☐ Recommended by ……

Dental Questionnaire

- Do your gums bleed when you brush your teeth? Yes ☐ No ☐
- Do you get food trapped between your teeth? Yes ☐ No ☐
- Do you have any concern about your breath? Yes ☐ No ☐
- Would you like to have whiter teeth? Yes ☐ No ☐
- Are you concerned with crooked or crowded teeth? Yes ☐ No ☐
- Would you like to improve the look of your smile? Yes ☐ No ☐
- What type of tooth brush do you use? soft☐ medium☐ hard☐ electric☐

I have a dental Insurance ☐ Name of Insurance……

I wish to be seen at the practice as a patient ☐ as a member ☐

Your Doctor's (GP) name & address……

……

Communication Consent: preferred and selected method of communication please tick:

PRACTICE SMS ☐ Email ☐ Letter ☐

Above are methods we would like to communicate with you regarding appointments & treatments, to be able to provide our duty of care

MARKETING (annual newsletter) SMS ☐ Email ☐ Letter ☐

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

Have you:	Yes	No	PLEASE GIVE DETAILS
Been told that you have heart problems, angina, blood pressure problems, or stroke?			
Had bruising or persistent bleeding following injury, tooth extraction or surgery?			
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 rheumatic fever or cholera?			
Had arthritis or joint replacement?			

Do you:	Yes	No	PLEASE GIVE DETAILS
Have a pacemaker or have had any heart surgery?			
Suffer from bronchitis, asthma or other chest condition?			
Have diabetes (or does anyone in your family)?			
Suffer from hay fever or eczema?			
Any infectious diseases (including HIV and hepatitis)?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Carry a warning card?			
Any other serious illness?			

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+☐

Alcohol consumptions units per week: None ☐ 1-5 ☐ 5-10 ☐ 10+☐

I understand and give consent to the following:

- When I accepted my Treatment Plan, payment will be made in full by the end of visit.
- Clinical photographs and radiographs might be taken for my treatment records
- I will be asked for an advanced payment for planned treatments and it will be a charge for appointment rebooked, missed or cancelled without 48 hours' notice. Please see our full cancellation policy.
- I will be contacted by email, mobile or mail for confirmation of appointments and other dental health related issues.

Signature…… Date……

Please kindly tell the dentist if you have any health issues or disability that the practice should be aware of to ensure that our services are appropriate to your needs. Many Thanks