Please give any other details which your dentist might need to know about, such as self-prescribed medicines(e.g. aspirin)	

SMILE CHECK: The purpose of this questionnaire is for you to analyse your own smile so that you can tell us how you feel about the appearance of your mouth or smile. We continually want to help fulfill your individual needs and wishes.

BELMONT PARK
DENTAL CARE

Questions	Yes	No	Details
Are you satisfied with your teeth and their appearance?			
Would you like your teeth whiter?			
Would you like your teeth to be straighter?			
Do you suffer from bad breath – halitosis?			
If you could alter your smile what would you most like to change?			

Signature:..... Date: .....

Patient / Parent / Guardian (delete as applicable)

confidential medical history form

BELMONT PARK
DENTAL CARE

Welcome to Belmont Park Dental Care. You will shortly be going through to see your dentist. Before you do, could you take a few moments to answer the questions on this form it will help us to tailor our services to your requirements.

Your Full Name:					
Title:		Date of Birth:		Sex:	Male / Female
Home Address:	Post Code:				
Home Tel:					
Mobile Tel:					
Email Address:					
NHS Number:					
Best method for contact:					
Occupation:					
Medical Doctor's Name:					
Medical Doctor's Address:					
Doctor's Telephone:					
When did you last receive dental treatment?					
Previous Dentist Details	Post Code:				
How did you hear about us (please tick)?	Leaflet ☐	Yell.com ☐	Yellow Pages ☐		
	Walking Past ☐	Street Survey ☐	Web Search ☐		
	Recommended ☐	The Mercury ☐	The New Shopper ☐		
	Other (please state)_____				

4 Belmont Park, London, SE13 5BJ tel: 0208 297 7792 web: www.johngintyandassociates.co.uk

Like all dentists, we ask our patients for information about their general dental health to help us treat them safely. Please answer the health questions contained in this medical history form and then sign the form on the back page. We will show you the form at later visits so that you can tell us whether there has been any changes in your general health. All information will be kept strictly confidential by the people caring for you.

Are you?	Yes	No	Details
Attending or receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medicines (e.g. tablets, inhalers, contraceptives, hormone replacement therapy)?			
Taking or have taken steroids in the last 2 years?			
Carrying a medical warning card?			

Do you suffer from?	Yes	No	Details
Allergies to any medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods?			
Hay fever or eczema or any other allergy?			
Bronchitis, asthma or other chest condition?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart problems, angina, blood pressure problems, or stroke?			
Diabetes (or does anyone in your family)?			
Arthritis?			
Bruise easily or suffer persistent bleeding following a tooth extraction or injury or does anyone in your family?			
Any infectious diseases (including HIV and hepatitis)?			

Women only:	Yes	No	Details
Is there any possibility that you may be pregnant?			
Have you had a baby in the last 12 months?			

Did you as a child or since, have:	Yes	No	Details
Rheumatic fever or chorea?			
Liver disease (e.g. jaundice, hepatitis) or kidney disease?			
Any other serious illness?			
A bad reaction to general or local anaesthetic?			
A joint replacement or other implant?			
Treatment that required you to be in the hospital?			
A pacemaker, heart surgery or brain surgery?			
A close relative (parent, sibling, child, grandparent or grandchild) with CreutzfeldtJakob Disease (CJD)?			
Ever had your blood refused by the Blood Transfusion Service?			

Drinking	Units per week
How many units of alcohol do you drink per week? (A unit is half a pint of lager, a single measure of spirits or a single glass of wine/aperitif.)	

Smoking and Chewing	Yes	No	In Past	Quantity
Do you smoke any tobacco products now (or did you in the past)? How many times per day?				
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)? How many times per day?				