dental menu

Please tick the relevant boxes to help us know your current dental concerns

- ❑ Would you like your teeth to look whiter or brighter?
- ❑ Are your teeth sensitive?
- ❑ Have you any teeth you think are unsightly, mis-shapen or out of line?
- ❑ Do you have any old crowns that now do not match your other teeth or have dark lines at the gums?
- ❑ Do you have any old or stained fillings that show when you smile?
- ❑ Do you have any silver fillings that you would like replacing with tooth coloured mercury free restorations so that they blend in better?
- ❑ Do you have any missing teeth that you would like replacing to improve your smile and your bite?
- ❑ Do you have an old, worn denture that looks false and feels false?
- ❑ Are your teeth stained or your gums red and swollen?
- ❑ Do your gums bleed when brushing?
- ❑ Do you get a bad taste in your mouth or around some teeth?
- ❑ Are you concerned that you may have bad breath?
- ❑ Do you play contact sports without wearing a gum shield to protect your teeth, smile and your bite?
- ❑ Do you have frown lines or crows feet and would like treatment to soften them?
- ❑ Do you have lips that are thin and would like treatment that would "plump" them up?

Signed_____ Date_____

Signed_____ Date_____

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Signed_____ Date_____

tlcdental

medical and dental history

TLC Dental, 4 Terrace Road, Plaistow, London, E13 0PB

T 0208 552 7552 F 0208 586 7241 E info@tlcdental.co.uk

www.tlcdental.co.uk

a personal dental assessment

If you are a new patient at TLC Dental, may we offer you a warm welcome. 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 take about five minutes to answer.

If you are an existing patient at TLC Dental we constantly aim to improve the service we offer you. Please could you take a few minutes to complete this Personal Dental Assessment and bring it with you to your next visit.

Please tell us:

Your full name _____

_____

Address _____

_____

_____

_____

Postcode _____

Daytime number _____

Ext _____

Evening number _____

Email _____

Date of birth _____

What is your occupation? _____

_____

Name and address of your doctor

_____

_____

_____

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?

- ❑ Convenient location
- ❑ I was recommended by a friend
- ❑ Family member already a patient here
- ❑ For emergency treatment only
- ❑ Located from website
- ❑ Telephone directory
- ❑ Another reason, please specify

_____

When did you visit your last dentist?

_____

Have you left another practice in order to come here? ❑ Yes ❑ No

If you think it is important to explain why, please do so.

_____

What are your reasons for attending here today?

_____

_____

Are you worried/anxious about seeing the dentist?

Yes ❑ No ❑

Are you concerned about the finances required?

Yes ❑ No ❑

confidential medical history

A Are you

1.	Attending or receiving any treatment from your doctor, hospital, clinic or specialist?	YES / NO .....
2.	Taking any medicines or tablets prescribed by your doctor? PLEASE ATTACH COPY IF 'YES'	YES / NO .....
3.	Allergic to penicillin or any other drug or substance or foods (eg latex/rubber)?	YES / NO .....
4.	Pregnant or likely to be so?	YES / NO .....
5.	Are you breast feeding?	YES / NO .....

B In the past have you

1.	Ever had a heart problem, angina, high or low blood pressure, heart attack or stroke?	YES / NO .....
2.	Ever had a heart valve replaced?	YES / NO .....
3.	Ever had rheumatic fever?	YES / NO .....
4.	Ever had jaundice, hepatitis, liver problems or kidney disease?	YES / NO .....
5.	Ever had asthma, bronchitis, hayfever or any serious chest infections?	YES / NO .....
6.	Had a blood transfusion from the Blood Transfusion Service?	YES / NO .....
7.	Ever had any blood related diseases?	YES / NO .....
8.	Ever had a bad reaction to a local or general anaesthetic?	YES / NO .....
9.	Ever had an operation or received hospital treatment?	YES / NO .....
10.	Had growth hormone treatment before the mid 1980's?	YES / NO .....

C Do you

1.	Have a pacemaker?	YES / NO .....
2.	Have fainting attacks, giddiness or epilepsy?	YES / NO .....
3.	Have diabetes?	YES / NO .....
4.	Carry a warning card?	YES / NO .....
5.	Bruise easily or have you ever bled excessively?	YES / NO .....
6.	Take or have you ever taken steroids?	YES / NO .....
7.	Do you smoke? Typically how many per day?	YES / NO .....
8.	Have a close relative (parent, sibling, grandparent or grandchild) with Creutzfeldt Jakob disease?	YES / NO .....
9.	Drink alcohol (A unit is half a lager, a single measure spirit or glass of wine)?	YES / NO How many units per week?
10.	Suffer from headaches or migraine?	YES / NO .....
11.	Suffer with Arthritis or have any joint replacements?	YES / NO .....
12.	Have any infectious diseases such as HIV, CJD or Hepatitis, if so what	YES / NO .....
13.	Have any hearing or sight impairments?	YES / NO .....
14.	Have any physical or mental disabilities?	YES / NO .....

PLEASE COMPLETE THE REVERSE OF THIS FORM