Personal Details

Please complete this form so we know more about you. You can print it out and bring it with you or e-mail it to reception@thirtythreedental.co.uk. We promise to keep this information completely confidential and only for our own use.

Full Name:

Address:

Date of Birth:

Mobile phone number:

(We will send you a text message to remind you about your appointments.)

Alternative number (optional):

E-mail address:

Occupation:

How did you hear about us?

Medical History

Your Doctor's name and address:

Please Tick	Yes	No
Are you receiving treatment from a Doctor, Hospital or Clinic?		
Are you taking any prescribed medications? (Please bring a list)		
Are you pregnant?		
Do you have any allergies to medications, substances or food?		
Do you suffer from hayfever or eczema?		
Do you suffer from asthma, bronchitis or any other chest conditions?		
Do you suffer from fainting, giddiness, blackouts or epilepsy?		
Do you suffer from any heart problems, angina, blood pressure or stroke?		
Do you have diabetes (or anyone else in your family?		
Do you suffer from arthritis?		
Do you bruise easily or have persistent bleeding following injury, extractions or		

surgery?		
Do you have any infectious diseases?		
Have you ever had Rheumatic fever?		
Have you ever had liver or kidney disease?		
Do you suffer from any other serious illness?		
Have you ever had your blood refused from a blood transfusion service?		
Have you ever had a bad reaction to general or local anaesthetic?		
Have you ever had a joint replacement or other implant?		
Have you ever had treatment that required you to be in hospital? If so, for what reason?		
Have you ever had heart surgery?		
Do you smoke tobacco products now or in the past? If so, how many a day?		
Do you chew tobacco, pan, use gutkha or supari now or in the past?		
Do you regularly drink alcohol? If so, what is your average weekly consumption?		

Signed: Date:

Smile Questionnaire

Please tell us about your concerns and how we can help you to have a healthy and attractive smile.

Please Tick	Yes	No
I wish my teeth were whiter and brighter.		
I would like to replace my old unsightly silver fillings with natural looking white ones.		
I have crowns that do not match my other teeth.		
I have missing teeth and do not like the gaps.		
Some of my teeth are misshapen.		
I feel self-conscious about my smile.		
My gums bleed when I brush my teeth.		
I have a bad taste in my mouth or around some of my teeth.		

I am concerned about bad breath.		
My teeth are weak and keep breaking.		
I grind my teeth at night.		
I experience headaches or migraines.		
I snore at night.		
I have a denture that looks and feels false.		
I have dentures that are loose and uncomfortable.		
I have pain from one or more of my teeth.		
My teeth are sensitive to temperature or pressure.		
I play a contact sport but do not have a fitted mouthguard.		
I am interested in implants.		
I am interested in complementary therapies.		
I am very anxious about receiving dental treatment.		

If you have any other concerns or questions please write some notes below so we can address them.

Thank you.

We very much look forward to meeting you.