BROOKLANDS
DENTAL CLINIC LTD

Patients Dental and Medical Questionnaire

Mr./Mrs./Ms/Miss/Dr. (Please Circle)

Full Name. ____________________ D.O.B ____________

House/Flat No. ____________________

Street ____________________

Town ____________ County ____________ Postcode ____________

Tel No. Home ____________________ Mobile ____________________

Email Address ____________________

Occupation ____________________ Work No. ____________________

Referred By ____________________ (If another patient please state name)

When did you last visit?

The Dentist ____________________ Hygienist ____________________

To help us provide the best possible treatment, dependent upon your needs, we would appreciate if you could indicate below which treatments intrest you?

Please tick the following:

Treatment of Pain Only	
Regular Check Ups	
Regular Hygiene for maintenance of healthy gums	
Cosmetic Treatment	
Whitening of your teeth	
Implants (replacement of missing teeth)	
White Fillings	
Facial Aesthetics	
Other	

How would you prefer to be contacted by us?

(Please tick one box for recalls and one box for confirmation)

Recall Examination	Email	Letter
Confirmation of Appointment	Email	Phone

Medical History Update

Do you have a history of. Or ever suffered from the following? (Please only tick those that apply)

Heart		Arthritis		Heart Surgery		Pacemaker	
Rheumatic Fever		Kidney		Liver Disease		Chest Problem	
Hayfever		Asthma		Diabetes		Anaemia	
Hepatitis		HIV		Epilepsy		High/Low BP	
Giddiness		Thyroid		Allergies		Other	

For Other and/or Allergies please give details

____

____

Have you ever had a bad reaction to a general or local anaesthetic? Yes/No

Are you under the care of a doctor at present? Yes/No

If yes, please give details ______________________________

____

Are you currently taking and medication? Yes/No

If yes, please give details ______________________________

____

If you are pregnant please give expected birth date ____________

If you are allergic to any drugs please give name of drug/s

____

Signature ____________________ **Date** ____________________