Your Contact Details

PLEASE COMPLETE IN BLOCK CAPITALS

Market Place Dentistry

Title		**First Name**	
Surname			
Date of Birth			
Address			
Mobile phone			
Other phone			
Email			
How did you find out about us?			
Why did you choose us?			

How we will contact you

We will use the information above to contact you with service messages, which include reminders about upcoming appointments, and letting you know when routine appointments are due.

Please send me appointment reminders:

By email ◯ By SMS ◯ I don't need a reminder ◯

Please contact me if it becomes possible to book appointments online

By Email ◯ **Yes** ◯ **No** **By SMS** ◯ **Yes** ◯ **No**

Please inform me of events or services you think I may be interested in

By Email ◯ **Yes** ◯ **No**

Sign: **Date:**

Health Questionnaire

Market Place Dentistry

Full Name:	**Doctor's practice:**
Date of Birth:	
Next of kin: (please provide name and phone number)	

Are you currently	**Y**	**N**	**Further details**
Receiving any treatment from a doctor, hospital or clinic?	◯	◯	
Taking any prescribed medications, including tablets, inhalers, injections, creams?	◯	◯	If yes, please list here:
Receiving or recently completed treatment for cancer?	◯	◯	
Carrying a medical warning card?	◯	◯	
Pregnant or possibly pregnant?	◯	◯	Due Date:
Allergic to anything?	◯	◯	Please list:

Have you ever had:	**Y**	**N**	**Further details**
A bad reaction to general or local anaesthetic?	◯	◯	
Heart surgery?	◯	◯	
Notification you may be at risk of variant Creutzfeldt-Jakob disease?	◯	◯	
Cold sores?	◯	◯	

Do you have, or receive treatment for:	**Y**	**N**	**Do you have, or receive treatment for:**	**Y**	**N**
Angina?	◯	◯	Diabetes?	◯	◯
High blood pressure?	◯	◯	Liver disease, including hepatitis?	◯	◯
Heart failure?	◯	◯	Kidney disease or transplantation?	◯	◯
Prosthetic heart valves?	◯	◯	HIV?	◯	◯
A pacemaker or internal defibrillator?	◯	◯	Fainting, giddiness, epilepsy or blackouts?	◯	◯
Other heart problems?	◯	◯	Bone or joint disease, including osteoporosis?	◯	◯
Learning difficulties?	◯	◯	TB or other infectious respiratory diseases?	◯	◯
Mental health problems?	◯	◯	Asthma, bronchitis, legionella or other non-contagious respiratory problems?	◯	◯
Easy bruising?	◯	◯			
Persistent bleeding following injury, tooth extraction or surgery?	◯	◯	Any other serious or infectious diseases or medical conditions?	◯	◯

If yes to any of the above, please give details:

Is there anything else your dentist may need to know about you such as self-prescribed medication, lack of mobility, deafness, etc?

Social History:

How many units of alcohol do you consume in an average week? (1 pint beer = 3 units, 1 large glass of wine = 3 units, 25ml of spirits = 1 unit)	
Have you smoked regularly in the past? If so, when did you stop?	
Do you currently smoke? If so, how many per day?	
Do you chew tobacco, guthka, supari or pan now or in the past?	

Dental Anxiety:

Please circle a number to show your level of dental anxiety

Not at all anxious — Extremely Anxious

1 2 3 4 5 6 7 8 9 10

Give more information if you like:

Completed by (please circle) : **Self** **Parent** **Guardian** **Other:**

Sign:

Date: