Welcome to Gentle Dental Care
Please complete the following form to help us best assess your dental health and personal needs.

Medical History

Personal Details

Mr / Mrs / Miss / Dr Full Name

Today's Date

Home Address

Home Tel

Post Code

Work Tel

Date of Birth

Occupation

Mobile Tel

How did you hear of us?

Email

Your Concerns

What would you like to discuss with the dentist?

Any other requirements?

How healthy do you feel your mouth is?	least healthy	1	2	3	4	5	6	7	8	9	10	most healthy
How important are your teeth are to you?	least Important	1	2	3	4	5	6	7	8	9	10	most Important
Do your teeth affect you in social situations?	least affected	1	2	3	4	5	6	7	8	9	10	most affected

Bite Assessment

	Yes	No
Do you clench or grind your teeth during the day or night?	☐	☐
Do your jaws feel tired when you wake up?	☐	☐
Do you suffer from chronic headaches, neck or shoulder pain?	☐	☐
Do you have pain in your jaw joint, ear or sides of your face?	☐	☐
Do your jaws click or pop when you open your mouth?	☐	☐
Do you have sinus trouble?	☐	☐
Do you have tinnitus, ringing in your ears?	☐	☐
Has it ever been difficult to move your jaw or open your mouth?	☐	☐
Have you ever hurt your jaw joints in an accident?	☐	☐
Do you tend to chew on only one side of your mouth?	☐	☐
Do crowns or fillings stop you biting normally or feel in the way?	☐	☐

Gentle
Dental Care

Medical History

Do you have or have you ever had any of the following:

	Yes	No
Heart Trouble	☐	☐
Stroke	☐	☐
Heart Attack	☐	☐
Damaged Heart Valves	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Chest Pain After Exercise	☐	☐
Shortness of Breath	☐	☐
Pacemaker	☐	☐
Fainting	☐	☐
Epilepsy	☐	☐
Emotional or Nervous Conditions	☐	☐
Tuberculosis	☐	☐
Sinus Trouble	☐	☐
Emphysema	☐	☐

	Yes	No
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Stomach Ulcers	☐	☐
Jaundice	☐	☐
Liver Disease	☐	☐
Hepatitis	☐	☐
HIV	☐	☐
Diabetes	☐	☐
Hypo- or Hyperthyrodism	☐	☐
Bleeding Problems	☐	☐
Osteoporosis	☐	☐
Arthritis	☐	☐
Cancer Therapy	☐	☐
Bone Diseases	☐	☐

Allergies

	Yes	No
Iodine	☐	☐
Antibiotics	☐	☐
Aspirin	☐	☐
Sedative	☐	☐
Codeine	☐	☐

Other

Are you pregnant? ..... Yes ☐ No ☐

No. of cigarettes per day? ..... ☐ Would you like to quit? Yes ☐ No ☐

Units of alcohol per week? ..... ☐

Are you interested in Botox or Fillers? ... Yes ☐ No ☐

Please list any other medical conditions and medications:

Doctor (GP)

Doctors Name _____ Practice Address _____

Specialist Doctors

Please list name, hospital and department of any Specialists who are looking after you:

Consent for Private Treatment

All the treatments carried out at Gentle Dental Care are private.
I understand that I am welcome to ask any questions about the treatment.
I wish to start treatment at Gentle Dental Care.

Patients Name _____ Patients Signature _____ Date _____

Do you know anyone who might be interested in our services? Yes ☐ No ☐

GDPR: Please tick to opt-in for marketing Yes ☐ No ☐

Gentle Dental Care