

Your details:

Surname: _____

First name(s): _____

Date of Birth: _____

Address: _____

Postcode: _____

Occupation: _____

Telephone: _____ Preferred contact

Home: _____

Work: _____

Mobile: _____

Email: _____

Previous dentist details: _____

How long since your last visit? _____ Years _____ Months

How did you hear about New Town Dental Care? _____

If internet search engine, which one? _____

On a scale of 1-10 how anxious do you get about a trip to the dentist?

(1 not anxious, 10 extremely anxious) 1 _____ 10

To help us assess your dental needs, please tick any of the issues below which concern you.

I feel that my teeth are too dark or stained?

I have old crowns or caps on my teeth that don't match my other teeth and/or have unsightly black lines above them?

I have old or stained fillings which are visible when I smile?

I have old, large or unsightly amalgam or silver fillings?

I am worried about the cost of treatment and how to pay for it?

I have an old denture that looks and/or feels false?

I grind and/or clench my teeth because of stress?

My gums bleed when I brush

I am concerned about bad breath

I have gaps that show in my mouth?

New Town Dental Care

