Strictly Confidential

New Patient Questionnaire

Title:_____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 would like my teeth to be whiter	☐
I don't like the appearance of my old crowns or fillings	☐
I would like straighter teeth	☐
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 am missing some teeth and I would like to fill the gaps	☐
I would like help to stop snoring	☐

Now please complete the medical questions on the second page.

NEW TOWN DENTAL CARE

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We ask you for information about your general health to help us treat you safely. Please complete the form and sign it where indicated. All information will be kept confidential by the people caring for you.

Doctors Name:_____

Doctors Address:_____

Are you currently:	Yes	No	Give details
Attending or receiving treatment from a doctor, hospital or specialist?	☐	☐	
Taking any medicines from your doctor? (Tablets, Ointments, injections or inhalers, including Contraceptives and hormone replacement therapy?)	☐	☐	
Allergic to any medicines or substances?	☐	☐	
Pregnant?	☐	☐	

Have you:	Yes	No	Give details
Had rheumatic fever?	☐	☐	
Ever been told you had a heart problem or heart attack, angina or blood pressure issues?	☐	☐	
Had any blood tests or inoculations?	☐	☐	
Had your blood refused by the blood transfusion service?	☐	☐	
Had a bad reaction to local or general anaesthetic?	☐	☐	
Had a joint replaced?	☐	☐	
Been hospitalised?	☐	☐	

Smoking	Yes	No	In past
Do you smoke any tobacco products now or in the past?	☐	☐	☐

Drinking

How many units of alcohol do you drink per week? ☐ Units per week

Do you:	Yes	No	Give details
Have arthritis?	☐	☐	
Have a pacemaker. Or had any form of heart surgery?	☐	☐	
Suffer from hayfever, eczema or other allergy?	☐	☐	
Suffer from bronchitis, asthma or other chest condition?	☐	☐	
Have fainting attacks, giddiness, blackouts or epilepsy?	☐	☐	
Have diabetes or does anyone in your family?	☐	☐	
Bruise easily following a tooth extraction, injury or surgery?	☐	☐	
Carry a medical warning card?	☐	☐	
Ever get cold sores?	☐	☐	
Had jaundice, liver, kidney disease or hepatitis?	☐	☐	

Please give any other details which your dentist might need to know about

Completed by (please tick) ☐ Self ☐ Parent ☐ Guardian

Signature _____ Date _____

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