(please tick all that apply)

SMILE CHECK:

Our aim is to boost your confidence with a smile you can be truly proud of.

This smile check questionnaire will help us to understand what you like about your smile, and whether you feel it could be improved.

	Yes	*No*
Are you self-conscious about the appearance of your teeth?	☐	☐
Are you happy with the colour of your teeth, fillings and crowns?	☐	☐
Are your teeth as bright and white as you would like them to be?	☐	☐
Do your gums bleed when you brush them?	☐	☐
Is there a bad taste in your mouth?	☐	☐
Do you have gaps that show or that you are unhappy with?	☐	☐
Do you have a denture which feels uncomfortable and looks false?	☐	☐
Are you concerned about dental charges and how to pay them?	☐	☐
Are you interested in any other information on facial rejuvenation?	☐	☐
Are you interested in enhanced facial aesthetics and our MediSpa service?	☐	☐

If you had the opportunity to change the way your teeth look and feel what would you like to see changed? .....

.....

Do you have any other dental concerns that you would like to raise with your dentist?

.....

We can help you with all of these issues. Please tick your concerns and hand this sheet to one of our team, we will then be able to discuss with you the options which are available for enhancing your smile. These discussions are, of course, on a no-obligation basis. **We want you to be happy with your smile!**

Date: ..... Signed: .....

Thank you for taking the time to complete this form - we appreciate it.

CrownWood Dental

Personal Medical History

To provide you with the most appropriate advice and dental treatment, your dentist needs to know about aspects of your health which may affect your treatment. We would ask that you complete this form so that your dentist can talk more fully to you before commencing treatment. The information that you provide will be treated in the strictest confidence and if you have any questions, please ask the dentist.

Title: ..... Forenames: ..... Surname: .....

Date of Birth: ..... Sex: (M/F) .....

E-mail address: .....

Address: .....

Tel (home): ..... (work): .....

(mobile): .....

Occupation: .....

We hope you will be very satisfied with the care you receive at CrownWood Dental. We would like to know what made you choose us.

(please tick all that apply)

Please indicate below:	*Yes*	*No*
Convenient location:	☐	☐
Recommended by a friend/family member:	☐	☐
Their name:		
Google/other search engine:	☐	☐
Our website:	☐	☐
Mailshot/promotions:	☐	☐
Local to CrownWood:	☐	☐
Another reason, please specify:	☐	☐

.....

(please tick all that apply)

	Yes	No
Date of last dental treatment:		
Are you an expectant mother?	☐	☐
If yes, please give expected due date:		
Doctor's name and address:		
Are you a smoker? *If so, how many per day?*	☐	☐
Do you drink alcohol? *If so, how many units a week?*	☐	☐

ARE YOU:

Are you exempt from paying dental charges?	☐	☐
If so, please state which exemption you receive:		
Receiving treatment from a doctor, hospital, clinic or alternative therapist?	☐	☐
If so, please give details:		
Taking any medicines from your doctor (tablets, ointments, injections, inhalers)?	☐	☐
If so, please state what medication you are taking:		
	☐	☐
Allergic to any medicines, foods or materials (i.e. penicillin or latex)?	☐	☐
If so, please give details:		

HAVE YOU, AS A CHILD OR SINCE:

Had rheumatic fever or chorea *(St Vitus Dance)* ?	☐	☐
Had jaundice? ☐ liver disease? ☐ kidney disease? ☐		☐
Ever been told you have a heart problem, angina, blood pressure problems, or had a heart attack or stroke?	☐	☐
Ever had your blood refused by the Blood Transfusion Service?	☐	☐
Had growth hormone treatment? *If so, when?*	☐	☐
Had a bad reaction to a general or local anaesthetic?	☐	☐
Had a joint replacement or other implant?	☐	☐
Been hospitalised? *If so, please give details*:	☐	☐

(please tick all that apply)

DO YOU:

	Yes	No		Yes	No
Believe you are in good health?	☐	☐			
If no, please give details:					
Have arthritis?	☐	☐			
Have a pacemaker?	☐	☐	Had any form of heart surgery?	☐	☐
Suffer from hay fever?	☐	☐	Eczema or any other allergy?	☐	☐
Suffer from bronchitis?	☐	☐	Asthma or other chest condition?	☐	☐
Have fainting attacks, giddiness, or blackouts?				☐	☐
Suffer from epilepsy?				☐	☐
Have diabetes?				☐	☐
Does anyone else in your family have diabetes?				☐	☐
If so, please give details:					
Have CJD or does anyone in your family?				☐	☐
Have you had any form of Hepatitis? either: A ☐ B ☐ C ☐ D ☐					☐
Bruise easily or, following an extraction, surgery or injury, have you bled so as to cause you to be worried?				☐	☐
Carry any health warning card?				☐	☐
Ever get cold sores?				☐	☐
Are there any other aspects concerning your health that you think your dentist should know about?				☐	☐

Please remember to fill in the back page.