



Title: _____ First name: _____ Surname: _____

Phone number: _____ E-mail: _____

Welcome to Kelsham Dental Care. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments, or fees, please feel free to ask. All information on this form is strictly confidential and will be used only to serve you better.

Medical History

Do you have any general health problems?
If so, please specify

Yes **No**

Are you currently under a physician's care?

Reason _____
Name and address of physician _____

Are you currently taking any drugs or medication?

If so, what?

To the best of your knowledge, are you or have you ever been afflicted with:

- | | | |
|----------------------|--------------------------|--------------------------|
| Heart Ailment | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Prolonged Bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| Healing Complication | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergy to any drugs | <input type="checkbox"/> | <input type="checkbox"/> |

Do any of your fillings show when you smile?

Yes **No**

If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead?

Have you ever had any teeth removed?

How long have these teeth been missing?

Do your gums bleed when brushing?

Do you ever avoid any part of the mouth while brushing?

Have you been instructed regarding proper home care?

Do you have an unpleasant taste or odor in your mouth?

Do you smoke?

Do you frequently snack between meals on sweets or chew gum?

How often do you brush your teeth?

How often do you use floss?

Do you want to learn to control dental disease and retain your teeth?

Has the fear of discomfort kept you from regular dental visits?

Are you deeply concerned about the finances required to return your mouth to excellent dental health?

When was your last dental appointment?

What did you have done?

How long since your last thorough examination with full mouth x-rays?

What prompted you to seek dental care at this time?

Dental History

Are your teeth sensitive to:

- | | | |
|------------------|--------------------------|--------------------------|
| Heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold? | <input type="checkbox"/> | <input type="checkbox"/> |
| Sweets? | <input type="checkbox"/> | <input type="checkbox"/> |
| Biting pressure? | <input type="checkbox"/> | <input type="checkbox"/> |

Does food constantly get stuck between certain teeth in your mouth?

Do you get frustrated because you always have to wait to be treated or repaired when you visit a dentist?

Are you dissatisfied with your teeth in any way?

Are you dissatisfied with the way your teeth looks?

For example: color, shape, spaces, etc.

Do you have any fillings that show in your front teeth?