



Welcome to Islington Green Dental Practice

Personal Information

Surname (and Title) _____

Forename (s) _____

Address _____

Postcode _____

Date of Birth _____

Tel (H) _____ Tel (W) _____

Tel (M) _____

Occupation _____

How did you find out about us _____

When last did you visit a dentist _____

Please note:

We need at least 48 hours notification if you cannot keep an appointment. Failure to do so may result in a professional fee charged at £26 per 10 minutes to cover our expenses.

Completed by: Self / Parent / Guardian

Signature

Date

Your comments regarding the service we provide will be appreciated. If you have any concerns or problems, feel free to approach a member of staff. We will do our best to be of help to you.

Certain medical conditions can affect dental treatment and vice versa.

ALL DETAILS WILL BE STRICTLY CONFIDENTIAL

Please tick:	Yes	No
Did you have rheumatic fever?		
Do you have, or had any heart complaints (including murmurs)?		
Do you suffer from diabetes?		
Do you suffer from epilepsy?		
Do you have chronic bronchitis or asthma?		
Do you suffer from excessive bleeding?		
Do you have blood pressure problems?		
Do you carry a warning card?		
Any other serious illnesses?		
Do you have any allergies to medicines, food or materials?		
Are you presently taking any medicines or tablets?		
Are you pregnant? If so, when is your baby due?		
Have you been treated with steroids in the past two years?		
Have you been advised to take antibiotics before dental treatment?		
Have you undergone any operations in the past 2 years?		

If **"Yes"**, please give us more information:

Please inform your Dentist if the following is true:

1. Have you, or are you suffering from any form of Hepatitis?
2. Are you HIV positive?
3. Are you suffering from any other serious illnesses?

Name, address and telephone number of your Doctor:

Please complete:

If you smoke, what is your average per day? (legal and/or illegal substances)	
How many units of alcohol do you consume per week?	

HOW DO YOU FEEL ABOUT YOUR SMILE?

Please tick:	Yes	No
Are there any spaces that you do not like?		
Is there a need for more space?		
Is crowding a problem?		
Do you have any chipped teeth that bother you?		
Do you like the shape of your teeth?		
Do you like the way your bottom teeth and top teeth fit together?		
Are there any discoloured or old fillings that bother you or you don't like seeing when you smile?		
Are your teeth as bright or white as you would like?		

What bothers you most about your smile? _____

How would you like your smile to look? _____

Clinical Photography:

At times clinical photography is helpful for planning your treatment and for use with our further education. Please tick the boxes you agree to, if any:

Your clinical records only	
Clinical records and teaching in clinical environment	
For use in medical publication	