DIAMOND DENTAL CARE
& IMPLANT CENTRE

Patient Details

Title:

First Name:

Last Name:

Sex:

Date of Birth:

Email Address:

Mobile Phone Number:

Home Phone Number:

Address Line 1:

Address Line 2:

Address Line 3:

State:

Post Code:

Occupation:

Work Phone:

Emergency Contact Name:

Emergency Contact Phone Number:

Emergency Contact Relation:

How did you hear about us?:

Signature

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Medical History

LIFESTYLE

How many times a day do you smoke tobacco products?

How many times a day do you chew tobacco, pan, gutkha or supari?

How many units of alcohol do you consume per week? (A unit of alcohol is a single measure of spirits, a glass of wine/aperitif, or a half pint of beer/lager)

No	Yes	
◉	○	Is your diet high in sugar/or high frequency?
◉	○	Do you drink a lot of fizzy or acidic drinks?
◉	○	Do you use recreational drugs?
◉	○	Are you or could you be Pregnant?
◉	○	Is there anything else your dentist should know?

If you selected yes to anything above, please give details

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HEART

No	Yes	
◉	○	Rheumatic Fever
◉	○	Heart Murmur
◉	○	High / Low Blood Pressure
◉	○	Angina
◉	○	Heart Surgery
◉	○	Thrombosis
◉	○	Pacemaker fitted
◉	○	Other Heart Condition

If you selected yes to any heart conditions, please give details

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BLOOD

No	Yes	
◉	○	Hepatitis A, B, C, D
◉	○	Anaemia
◉	○	H.I.V. / AIDS
◉	○	Sickle Cell
◉	○	Abnormal Blood Test
◉	○	Haemophilia
◉	○	Blood refused by transfusion service
◉	○	Other Blood Condition

If you selected yes to any blood conditions, please give details

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ALLERGIES

No	Yes	
◉	○	Penicillin
◉	○	Latex
◉	○	Hay Fever
◉	○	Medicine
◉	○	Anti-tetanus Serum
◉	○	Plants
◉	○	Eczema
◉	○	Food
◉	○	General Anaesthetic
◉	○	Aspirin
◉	○	Local Anaesthetic
◉	○	Other Allergy

If you selected yes to any allergies, please give details

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WARNINGS

No	Yes	
◉	○	Do you have a hearing or sight impairment?
◉	○	Do you have a problem being reclined?
◉	○	Do you require Antibiotic Cover?
◉	○	Have you had steroids in the last 2 years?
◉	○	Do you have bruising or persistent bleeding after injury, surgery, or tooth extraction?
◉	○	Do you carry a Warning Card?
◉	○	Are you currently having treatment from a doctor, hospital or clinic?
◉	○	Have you ever had treatment that required you to be hospitalised?

If you selected yes to warnings above, please give details

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CHEST

No	Yes	
◉	○	Bronchitis
◉	○	Emphysema
◉	○	Cystic Fibrosis
◉	○	Pneumonia
◉	○	Pleurisy
◉	○	Chest Surgery
◉	○	Asthma
◉	○	Other Chest Condition

If you selected yes to any chest conditions, please give details

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OTHER

No	Yes	
◉	○	Liver Disease
◉	○	Kidney Disease
◉	○	Diabetes / Family with Diabetes
◉	○	Epilepsy
◉	○	Acid Reflux or Eating Disorder
◉	○	Hiatus Hernia
◉	○	Bone or Joint Disease / Osteoporosis
◉	○	Artificial Joint
◉	○	Fainting Attacks or Blackouts
◉	○	Giddiness
◉	○	Any past Serious Illness or Infectious Disease
◉	○	Cancer / Radiotherapy
◉	○	Depressive Illness
◉	○	Stroke
◉	○	Nervous Problems
◉	○	Tuberculosis
◉	○	Severe Headaches
◉	○	Cold Sores

Please give details for anything selected yes above

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OTHER CONTINUED

Please list and state doses for any prescribed medicines, tablets, ointments, injections or inhalers (inc. contraceptives and HRT) that you are taking:

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Oral Health Survey

Areas of Concern

No	Yes	
◉	○	I have pain or sensitivity in my teeth or gums.
◉	○	My gums appear red and swollen, or bleed when brushed.
◉	○	I am worried about bad breath or a bad taste in my mouth.
◉	○	I have a dry mouth.
◉	○	I find it difficult to chew.
◉	○	I have a clicking or pain in my jaw.

Appearance

No	Yes	
◉	○	I am dissatisfied with the appearance of my teeth.
◉	○	I feel self-conscious when I smile.
◉	○	I wish some of my teeth were shaped differently.
◉	○	I have irregularly positioned teeth that I dislike.
◉	○	I have chips or gaps in my teeth that worry me.
◉	○	I have discoloured teeth that are noticeable.
◉	○	I wish my fillings matched the colour of my teeth.
◉	○	I have missing teeth that concern me.
◉	○	I am concerned about the appearance of wrinkles on my face.
◉	○	I would like younger looking skin.

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Information

No	Yes	
◉	○	I would like to know more about adult braces.
◉	○	I would like to find out more about teeth whitening.
◉	○	I would like to find out about Snore Guards.
◉	○	I would be interested in advice on a better toothbrush or brushing technique.
◉	○	I would like to know about stain removal from my teeth.
◉	○	I would like more information about clear/invisible braces.
◉	○	I am interested in finding out more about dental implants.
◉	○	I am nervous visiting the dentist and would like more information about my options.
◉	○	I am interested in learning more about facial aesthetic treatments.

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Other Questions

If you could change your smile, what you would you most like to change?

Is there anything else you would like to tell the dentist about your smile?

No	Yes	
◉	○	I would like to have relevant information sent to me.