Kelsham
DENTAL CARE

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

	Yes	No
Do you have any general health problems? If so, please specify	☐	☐
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 you knowledge, are you or have you ever been afflicted with:		
Heart Ailment	☐	☐
Diabetes	☐	☐
Rheumatic Fever	☐	☐
Epilepsy	☐	☐
High Blood Pressure	☐	☐
Respiratory Disease	☐	☐
Hepatitis	☐	☐
Prolonged Bleeding	☐	☐
Healing Complication	☐	☐
Allergy to any drugs	☐	☐

Dental History

	Yes	No
Are your teeth sensitive to:		
Heat?	☐	☐
Cold?	☐	☐
Sweets?	☐	☐
Biting pressure?	☐	☐
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?	☐	☐
Do any of your fillings show when you smile?	☐	☐
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 eximination with full mouth x-rays?		
What prompted you to seek dental care at this time?		

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