The Paddington Dental Surgery
Cosmetic and General Dentistry

Patient Information

The Paddington Dental Surgery team welcomes you to the practice.

In order to provide you with the very best care, we ask you to complete this questionnaire.

Personal Details

Name ..... Date of Birth .....

Address ..... Postcode .....

Best contact number ..... Email address ..... Occupation .....

Who can we thank for referring you to our clinic? .....

How would you like us to communicate with you? ☐ Email ☐ Phone call ☐ Text

In case of an emergency, please contact:

Name ..... Relationship ..... Contact number .....

Medical History

Name of Physician ..... Most recent physical examination .....

Purpose .....

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you require prophylactic antibiotic cover ..... Yes / No / Unsure

Do you have or have you ever had:

1. hospitalisation for illness or injury ..... Yes / No
2. an allergic reaction to
   - aspirin, ibuprofen, paracetamol, codeine ..... Yes / No
   - penicillin ..... Yes / No
   - erythromycin ..... Yes / No
   - lactose ..... Yes / No
   - latex ..... Yes / No
   - local anesthetic ..... Yes / No
   - fluoride ..... Yes / No
   - metals (nickel, gold, silver) ..... Yes / No
   - other .....
3. heart problems, or cardiac stent within the last six months ..... Yes / No
4. history of infective endocarditis ..... Yes / No
5. artificial heart valve, repaired heart defect ..... Yes / No
6. pacemaker or implantable defibrilator ..... Yes / No
7. orthopedic implant (joint replacement) ..... Yes / No
8. rheumatic or scarlet fever ..... Yes / No
9. high or low blood pressure ..... Yes / No
10. a stroke (taking blood thinners) ..... Yes / No
11. anemia or other blood disorder ..... Yes / No
12. prolonged bleeding due to a slight cut ..... Yes / No
13. emphysema, shortness of breath, asthma ..... Yes / No
14. tuberculosis, measles, chicken pox ..... Yes / No
15. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) .. Yes / No
16. kidney disease ..... Yes / No
17. liver disease ..... Yes / No
18. jaundice ..... Yes / No
19. thyroid, parathyroid disease, or calcium deficiency ..... Yes / No
20. high cholesterol or taking statin drugs ..... Yes / No
21. diabetes ..... Yes / No
22. stomach or duodenal ulcer ..... Yes / No
23. digestive disorders (i.e. celiac disease, gastric reflux) ..... Yes / No
24. osteoporosis/osteopenia (i.e. taking bisphosphonates) ..... Yes / No
25. arthritis ..... Yes / No
26. autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma) ..... Yes / No
27. glaucoma ..... Yes / No
28. head, neck or back injuries ..... Yes / No
29. epilepsy, convulsions (seizures) ..... Yes / No
30. neurological disorders (ADD / ADHD, prion disease) ..... Yes / No
31. viral infections and cold sores ..... Yes / No
32. any lumps or a swelling in the mouth ..... Yes / No
33. hives, skin rash, hay fever ..... Yes / No
34. hepatitis (type) ..... Yes / No
35. HIV / AIDS ..... Yes / No
36. radiation therapy ..... Yes / No
37. chemotherapy, immunosuppressive medication ..... Yes / No
38. psychiatric treatment ..... Yes / No
39. antidepressant medication ..... Yes / No
40. wear contact lenses ..... Yes / No

Are you:

41. presently being treated for any illness ..... Yes / No
42. aware of a change in your health in the last 48 hours (i.e. fever, chills, new cough, diarrhea) ..... Yes / No
43. nervous / anxious ..... Yes / No
44. often exhausted or fatigued ..... Yes / No
45. often unhappy or depressed ..... Yes / No
46. experiencing frequent headaches ..... Yes / No
47. a smoker, smoked previously or use smokeless tobacco ..... Yes / No
48. taking birth control pills ..... Yes / No
49. currently pregnant or breastfeeding ..... Yes / No

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (including Botox, Collagen Injections) .....

.....

Please list all medications, supplements, and or vitamins you are taking:

Drug	Purpose	Drug	Purpose
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

PTO

Dental History

Previous dentist ..... How long had you been a patient? (months/years) .....

Date of most recent dental exam ..... Date of most recent x-rays ..... Date of most recent treatment .....

Date of most recent clean ..... Have you had your teeth cleaned by a hygienist or periodontist? .....

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

How would you rate the condition of your teeth: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is your immediate concern? .....

Please answer yes or no to the following:

Personal History

1. Are you fearful of dental treatment? How fearful, on scale of 1 (least) to 10 (most) .....Yes / No
2. Have you had an unfavourable dental experience? .....Yes / No
3. Have you ever had complications from past dental treatment? .....Yes / No
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? .....Yes / No
5. Have you ever had braces, orthodontic treatment or your bite adjusted? .....Yes / No

Gum and bone

7. Do your gums bleed or are they painful when brushing or flossing? .....Yes / No
8. Have you even been treated for gum disease or been told you have lost bone around your teeth? .....Yes / No
9. Have you ever noticed an unpleasant taste or odor in your mouth? .....Yes / No
10. Is there anyone with a history of periodontal disease in your family? .....Yes / No
11. Have you ever experienced gum recession? .....Yes / No
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? .....Yes / No
13. Have you ever experienced a burning or painful sensation in your mouth not related to your teeth? .....Yes / No

Tooth structure

14. Have you had any cavities within the past 3 years? .....Yes / No
15. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? .....Yes / No
16. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? .....Yes / No
17. Do you have grooves or notches on your teeth near the gum line? .....Yes / No
18. Have you ever broken teeth, chipped teeth, or had a cracked filling? .....Yes / No
19. Do you frequently get food caught between any teeth? .....Yes / No
20. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? .....Yes / No

Bite and jaw joint

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) .....Yes / No
22. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? .....Yes / No
23. Have your teeth changed in the last 5 years, become shorter, thinner or worn? .....Yes / No
24. Are your teeth becoming more crooked, crowded or overlapped? .....Yes / No
25. Are your teeth developing spaces or becoming more loose? .....Yes / No
26. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? .....Yes / No
27. Do you clench your teeth during the day or night? .....Yes / No
28. Do you have any problems with sleep (e.g. restlessness), wake up with a headache or a tenderness of your teeth? .....Yes / No
29. Do you wear or have you ever worn a bite appliance? .....Yes / No

Smile characteristics

30. Have you felt uncomfortable or self conscious about the appearance of your teeth? .....Yes / No
31. Is there anything about the appearance of your teeth that you would like to change? .....Yes / No
32. Have you ever whitened (bleached) your teeth? .....Yes / No
33. Have you been disappointed with the appearance of previous dental work? .....Yes / No

Financial Terms

We are a non-account practice. We accept all major credit cards and debit cards. Payment is required at the completion of each visit. As a courtesy, we will endeavour to contact you to confirm your appointment. If you have not heard from us, please contact the surgery as unconfirmed appointments will be cancelled. If you are unable to keep your appointment, please notify us as soon as possible by telephone (not by email or sms). Failure to attend your appointment, or cancellation with 48 hours, will incur a fee. Your dental treatment is an investment in your health and wellbeing. Our goal is to provide you with optimal care, based upon your individual needs. Thank you for choosing our surgery.

Patient signature ..... Date .....

Parent / Guardian name ..... Signature ..... Date .....