

smiles in the city



BOW LANE

DENTAL GROUP

Your personal dental assessment

Your first step to a
Bow Lane Signature Smile™

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Welcome to **Bow Lane Dental Group**

In order to provide you with the best care, we ask that you complete the following confidential questions.

Title

Name

Home Address.....

.....

.....

Post Code.....

Home telephone..... Mobile

.....

Business address.....

.....

.....

Postcode

Business telephone

Email

Dental Insurance..... Yes No

Date of birth.....

My last dental examination was on

How did you here about the practice.....

Dentistry focused on giving you the **best smile** possible and helping you maintain it for life

	YES	NO
Are you happy with your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your teeth to look whiter or brighter?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive?	<input type="checkbox"/>	<input type="checkbox"/>
Have you any teeth you think are unsightly, misshapen or out of line?	<input type="checkbox"/>	<input type="checkbox"/>
Are you concerned you may have bad breath or an unpleasant taste in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you're brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>
Are you concerned about:		
<input type="checkbox"/> Old crowns that now do not match your other teeth or have dark lines at the gum?		
<input type="checkbox"/> Old or stained fillings that show when you smile?		
<input type="checkbox"/> Silver fillings that you would like replacing with tooth coloured restorations so that they blend in better?		
<input type="checkbox"/> Any missing teeth that you would like to replace?		
Do you suffer from headaches/neck aches or shoulder pain?	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>

The health questionnaire you are about to fill out is important to your dentist. Do not worry about questions you cannot answer, but feel free to discuss with your dentist.

Are You?	YES	NO
Receiving treatment from a doctor, hospital or clinic	<input type="checkbox"/>	<input type="checkbox"/>
Taking any pills, medicines or tablets	<input type="checkbox"/>	<input type="checkbox"/>
Allergic or have you reacted adversely to:		
Penicillin or any other drug or medicine	<input type="checkbox"/>	<input type="checkbox"/>
Latex or other materials	<input type="checkbox"/>	<input type="checkbox"/>
Taking any of the following:		
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants	<input type="checkbox"/>	<input type="checkbox"/>
Medicine for high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (steroids)	<input type="checkbox"/>	<input type="checkbox"/>
Insulin or other medication for diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

In the past have you?

YES **NO**

Had any serious illness or operations

Had any of the following diseases or problems:

Rheumatic fever or rheumatic heart disease

Heart trouble, replacement heart valve, high blood pressure or stroke

Sinus trouble

Asthma

Diabetes

Hepatitis or HIV

Had abnormal bleeding associated with previous extractions, surgery or trauma

Had any problems with previous dental treatment

Do you smoke?

Number per day

Women only

Is there any possibility that you may be pregnant

Estimated date of delivery

Remarks:

Signature of patient Date

Signature of dentist Date



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Thank you

for taking the time to
answer our questions



INVESTOR IN PEOPLE