Contact Us: **Telephone:** 066 712 1275 **Email:** info@tdic.ie

tralee dental and implant clinic

EXCELLENCE IN DENTISTRY

Your Personal Dental Assessment

If you are attending us for the first time please print out and complete this form and bring it on your first visit.

Personal Details

Title: Name:

Address:

Date of Birth:

Telephone (daytime):

Telephone (evening):

E-mail address:

Business details

Address:

Postcode:

Telephone (daytime):

E-mail address:

Occupation:

Dental History

When was your last dental examination:

How did you hear about us?

Do you have dental insurance? ☐ Yes ☐ No

About You

Q: Are you happy with your smile? ☐ Yes ☐ No

Q: Would you like your teeth to look whiter or brighter? ☐ Yes ☐ No

Q: Are your teeth sensitive? ☐ Yes ☐ No

Q: Have you any teeth you think are unsightly, misshapen or out of line? ☐ Yes ☐ No

Q: Are you concerned you may have bad breath or an unpleasant taste in your mouth? ☐ Yes ☐ No

Q: Do your gums bleed when brushing or flossing? ☐ Yes ☐ No

Q: Do you suffer from headaches/neck aches or shoulder pain? ☐ Yes ☐ No

Q: Do you clench or grind your teeth? ☐ Yes ☐ No

Q: Do you smoke? ☐ Yes ☐ No

If so, how many a day?

Q: Are you concerned about:

Old crowns that do not do not match your other teeth or have dark lines at the gum? ☐ Yes ☐ No

Old or stained fillings that show when you smile? ☐ Yes ☐ No

Silver fillings that you would like replacing with tooth coloured restorations? ☐ Yes ☐ No

Any missing teeth that you would like to replace? ☐ Yes ☐ No

Are you...

Q: Fit and healthy? ☐ Yes ☐ No

Q: Taking pills, medicines or tablets? ☐ Yes ☐ No

Q: Allergic or have reacted adversely:

Penicillin or any other drug or medicine? ☐ Yes ☐ No

Latex or other materials? ☐ Yes ☐ No

Costume jewellery or other metals? ☐ Yes ☐ No

Q: Taking any of the following:

Antibiotics? ☐ Yes ☐ No

Anticoagulants? ☐ Yes ☐ No

Medicine for high blood pressure? ☐ Yes ☐ No

Cortisone (steroids)? ☐ Yes ☐ No

Insulin or other medication for diabetes? ☐ Yes ☐ No

Tablets for Osteoporosis (bisphosphonates)? ☐ Yes ☐ No

Other? ☐ Yes ☐ No

In the past have you...

Q: Had any serious illness or operation? ☐ Yes ☐ No

Q: Had any of the following diseases or problems:

Rheumatic fever or rheumatic heart disease? ☐ Yes ☐ No

Heart trouble, replacement heart valve, high blood pressur or stroke? ☐ Yes ☐ No

Sinus trouble? ☐ Yes ☐ No

Asthma? ☐ Yes ☐ No

Diabetes? ☐ Yes ☐ No

Hepatitis or HIV? ☐ Yes ☐ No

Q: Had abnormal bleeding associated with previous extractions, surgery or trauma? ☐ Yes ☐ No

Q: Had any problems with previous dental treatment? ☐ Yes ☐ No

Women only

Q: Is there a possibility that you may be pregnant? ☐ Yes ☐ No

If so, what is your estimated date of delivery?

Final Comments

Q: Is there anything else you would like to tell us?