



NEW PATIENT QUESTIONNAIRE

Please print a copy of this form, complete by hand and bring it with you to your first appointment

So that we may provide you with the best care, please complete the following questionnaire. All information will be kept strictly confidential.

PERSONAL AND CONTACT DETAILS

Title First name Surname

Home address including postcode Date of birth

Home telephone

Mobile

Work Telephone

Occupation

E-mail address

We are introducing text and e-mail appointment reminders. Please indicate if you would like to receive your appointment reminders in this way.

Text to your mobile E-mail

In the event of an emergency please contact

Name Telephone

Relationship to you

Doctor's details

Doctor's Name Telephone

Doctor's address including postcode

How did you hear about the Charlbury Dental Practice?

Advertisement Yellow pages Internet Family/Friends Word of mouth

Referral by another patient

How long is it since your last dental visit?

YOUR DENTAL CONCERNS

Do you have any specific dental concerns?

If yes, please explain what they are:

Do you think your teeth are unsightly, misshapen or crooked?

Yes No

Are your teeth sensitive to hot, cold or sweet food or drinks?

Yes No

Are you happy with your smile?

Yes No

If not, please explain why:

Would you like to improve your smile?

Yes No

Would you like your teeth to be whiter?

Yes No

Do you have old crowns that do not match your other teeth or have dark lines at the gum?

Yes No

Would you like to change your black or silver filling to white ones?

Yes No

Do you suffer from headaches or migraines?

Yes No

Do you snore?

Yes No

If yes, does this cause a problem for you, or for anyone else?

Yes No

Do your gums ever bleed when you brush or floss?

Yes No

Do you have an unpleasant taste in your mouth or believe that you might have bad breath?

Yes No

Are you concerned about old or stained fillings that show when you smile?

Yes No

Do you have any gaps, or missing teeth, which you would like to be rid of?

Yes No

Do you think you might clench or grind your teeth?

Yes No

Signature of Patient _____

Print name _____

Date _____

Thank you for taking the time to complete this questionnaire

The Charlbury Dental Practice

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