NEW PATIENT QUESTIONNAIRE

NAME:

How would you like us to address you?

ADDRESS:

DATE OF BIRTH

TELEPHONE NUMBERS
daytime

evening

Mobile

Email address

How would you prefer to be contacted ?

Doctor:

Address:

Previous dentist

When did you last visit a dentist?

Have you experienced any problems with dental treatment in the past?

How did you hear about our practice? (if you have been referred by one of our current patients please tell us who so we can thank them)

SMILE CHECK

Do you like your smile?

Would you like your teeth to look whiter and brighter?

Do you have old crowns/fillings that no longer match the colour of your natural teeth or have discoloured edges?

Do you have gaps in your teeth that you would like filled?

Do you wear a denture that is old or worn or ill-fitting?

Are your teeth sensitive to hot, cold or sweet things?

Do your gums ever bleed when you brush your teeth?

Do you ever get a bad taste in your mouth or bad breath?

Are you self-conscious about your teeth and hide them when you smile?

Do you play contact sports?

And lastly, If you could change anything about your smile, what would it be?

Please tell the dentist if you have a disability that the practice should be aware of to ensure that our services
are convenient to your needs — would you prefer us to use a ground floor surgery?