Patient Assessment

Welcome to Brucegate Dental Practice.

We endeavour to provide excellent modern Patient and Dental Care.

In order to help us assess your past Dental Treatment, Your Concerns and address your Current and Future Dental needs, we would be very grateful if you could answer the following questions, in order to help with your diagnosis and comprehensive treatment planning.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Is this a one off Appointment or would you like to join the practice? |  | | | | |
| Your Full Name |  | | | | |
| Your Occupation |  | | | | |
| When did you last visit a dentist? |  | | | | |
| Why did you leave your previous practice? |  | | | | |
| Are you anxious about dental treatment and if so, which part of treatment is it that concerns you? |  | | | | |
| Do you smoke now, or in past, and if so how many per day? |  | | | | |
| Do you currently have any pain or problems with your teeth or mouth? |  | | | | |
| Have you had a lot of dental treatment in the past such as large fillings, root canal treatment, extractions or crowns? |  | | | | |
| Do you drink many sugary drinks such as tea, coffee, squash, fizzy drinks, fruit juice? |  | | | | |
| Do you eat many sweets/mints/chocs? |  | | | | |
| Do you currently wear any dentures? Please tick | YES / NO | | Are you happy with them? | | |
| Are they loose? | | How old are they? | | |
| How often do you brush your teeth? |  | | | | |
| Do you use any of the following? (please tick) | Manual tooth brush | Electric tooth brush | | | Fluoride toothpaste |
| Interdental brushes | Floss | | | Mouthwash |
|  | Other: |  | | |  |
| Do your gums bleed when you brush your teeth? |  | | | | |
| Do you suffer from bad breath or sometimes get a bad taste in your mouth? |  | | | | |
| Do you have any wobbly or loose teeth? |  | | | | |
| Do your teeth seem to have moved or changed position at all? |  | | | | |
| Do you have sensitive teeth with hot, cold or sweet food and drinks? |  | | | | |
| Does your Jaw joint click or make a noise when you open or close? |  | | | | |
| Does your jaw lock at all? |  | | | | |
| Do you suffer from headaches or migraine, neck and shoulder ache or upper back ache? |  | | | | |
| Do you chew gum, bite nails frequently, or grind/clench your teeth? |  | | | | |
| Are you happy with the appearance of your teeth? |  | | | | |
| If not, what would you like to change?(please tick) | Position of teeth | | |  | |
| Shape of teeth | | |  | |
| Colour | | |  | |
| Denture appearance | | |  | |
| Alternative to denture | | |  | |
| Spaces filled | | |  | |
| Metal fills changes to white | | |  | |
| Do you have any other concerns about your mouth and teeth? |  | | | | |
| Would you like further information about possible treatments available and if so what would be of interest to you? |  | | | | |
| Are you interested in joining a Denplan Care scheme and would like further information? |  | | | | |
| Your Signature  ………………………………………………………………………….. | Dentist Signature  …………………………………………………………………………….. | | | | |

Many thanks for your time..