T: 020 7624 2434
T: 020 7624 7171

info@shapedental.com
www.shapedental.com

New Patient Form

Welcome to our surgery
Please take time to answer all questions as completely as possible. This will greatly assist us in providing the best treatment for you.
All information will be treated with professional confidentiality.

Please print
FULL NAME Mr/Mrs/Ms________________________________

ADDRESS Street Name & No.________________________________
Postcode________________________________

TELEPHONE Home________________Mobile________________
Work ________________

EMAIL________________________________

DATE OF BIRTH________________________________

Person responsible for fees________________________________
Who recommended you to us?________________________________
In case of Emergency contact details________________________________
What private dental cover/insurance do you have?________________________________
Medical Practitioner Name________________________________
Telephone No.________________________________

Do you suffer from the following?	**now**	**previously**	
1. Heart disease/vascular disorder	□ yes	□ yes	□ no
2. Heart surgery	□ yes	□ yes	□ no
3. High blood pressure	□ yes	□ yes	□ no
4. Blood disease/bleeding disorder	□ yes	□ yes	□ no
5. Rheumatic fever	□ yes	□ yes	□ no
6. Arthritis/Osteoporosis	□ yes	□ yes	□ no
7. Hepatitis A, B or C	□ yes	□ yes	□ no
8. Are you a carrier of Hepatitis	□ yes	□ yes	□ no
9. Thyroid disorder	□ yes	□ yes	□ no
10. Asthma/Bronchitis/other lung disorders	□ yes	□ yes	□ no
11. Liver or Kidney disease	□ yes	□ yes	□ no
12. Epilepsy	□ yes	□ yes	□ no
13. Ulcers	□ yes	□ yes	□ no
14. Diabetes	□ yes	□ yes	□ no
15. Radiotherapy/Chemotherapy	□ yes	□ yes	□ no
16. Have you ever had a blood transfusion?	□ yes	□ yes	□ no
17. Have you used intravenous drugs?	□ yes	□ yes	□ no
18. Are you pregnant?	□ yes	□ yes	□ no
19. Other health problems?	□ yes	□ yes	□ no

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Do you have allergies? If so, please state:____

____

Are you currently taking any medications? If so, please state name & daily dose:_____________

____

Reasons for attending:____

____

Please indicate if you have problems with any of the following:

- □ Jaw problems
- □ Toothache
- □ Sensitive teeth (hot or cold)
- □ Bleeding gums
- □ Food Impaction
- □ Missing or loose teeth

Comments____

____

How do you feel about the appearance of your teeth?

I am happy with the appearance____

Not great, but not a priority____

I would like an improvement____

Temporo-Mandibular joints (jaw point)

Do you have:

Frequent headaches or ringing in ears?____

A click or grate when you open or close your mouth?______________________________________

Pain from your joints or face?____

A stiff or sore jaw in the morning?____

A clenching or grinding habit?____

Other

Are you nervous of dental treatment?____

What concerns you most?____

When did you last have radiographs (x-rays) taken of your mouth?___________________________

Patient’s signature____Date____________

Doctor’s signature____Date____________