NEW PATIENT QUESTIONNAIRE

Strictly Confidential

PERSONAL DETAILS:

Title:	Forename(s):	Surname:
Date of Birth:	e-mail address:	
Home Address:		
		Postcode:
Telephone (home):	Telephone (work):	
Telephone (mobile):		

CONTACT DETAILS IN THE EVENT OF AN EMERGENCY:

Title:	Forename(s):	
Date of Birth:	Surname:	
Address:		
		Postcode:
Telephone (home):	Telephone (work):	
Telephone (mobile):		

Dear Patient

Welcome to Langmans & Associates Dental Health Centres. Please take a few moments to read and answer the questions below to help us understand your treatment needs.

PREVIOUS DENTAL EXPERIENCE:

When was the last time you visited the dentist?	yrs		months	
Have you had any bad experiences with dental treatment in the past?	Yes		No	
Are you nervous or anxious when visiting the dentist? (Please give details below if you wish.)	Yes		No	
Would you like further information on the sedation options we can offer?	Yes		No	

I HAVE REQUESTED TO JOIN THIS PRACTICE TO OBTAIN: (PLEASE TICK ALL THAT APPLY)

I would like to join as a Private patient.	
A comprehensive examination of my entire mouth and a consultation regarding my treatment needs and options.	
A smile design consultation to learn more about my cosmetic treatment options.	
A 2nd opinion concerning treatment options present elsewhere.	
An emergency appointment as I am in pain: (Briefly describe the problem)	
Other: (Please explain)	

YOUR DENTAL CONCERNS: ARE YOU CONCERNED ABOUT ANY OF THE FOLLOWING:

	Yes	No
Unsightly, discoloured, misshapen or crooked teeth?		
Sensitivity to hot, cold or sweet food or drinks?		
An unpleasant taste in your mouth or do you believe you might have bad breath?		
Bleeding gums when brushing or flossing?		
Gaps or missing teeth?		
Do you think you might clench or grind your teeth?		

P.T.O

NEW PATIENT QUESTIONNAIRE (continued)

TREATMENTS FOR YOU:

Please tick any of the treatments or services below that interest you:

Tooth Whitening	☐	Replacement of worn fillings	☐
Dental Implants	☐	Minimally invasive cosmetic treatment	☐
Implant retained dentures	☐	Hygienist appointments & oral hygiene advice	☐
Treatment for Headaches or Snoring	☐	Mouthguards / Sports Gumshields	☐
White Fillings	☐	Orthodontics (teeth straightening)	☐
New Dentures	☐	Replacement of Existing Dentures	☐

Are there any other treatments not listed above that you would like to discuss?

Please indicate if you prefer a male or female dentist or don't mind?

Are you able to make 2 flights of stairs? Yes / No
If not..................do you mind going in a platform lift? Yes / No

Is there any further information about you that would help us to assist you more thoroughly?

ONE LAST THING:

HOW DID YOU HEAR ABOUT THE PRACTICE?

Recommendation	☐	Live Locally	☐	Passing The Door	☐
NHS Direct	☐	Practice Leaflet	☐	Practice Website	☐
Advertisement	☐				

Any other means: Please state: ______

Signature of Patient: ______ **Date:** ______

Thankyou for taking the time to complete this questionnaire.

We very much value feedback about our services so please feel free to comment at reception or provide suggestions in our suggestion box.

For Practice Use Only: Patient Alternative Reference Number: ______