

## Welcome to UltraSmile\* Dentistry.

In order to provide you with the best dental care, we ask that you complete the following confidential registration form:

### About\* you.

<b>Title</b>	<input type="radio"/> Mr	<input type="radio"/> Mrs	<input type="radio"/> Miss	<input type="radio"/> Ms	<input type="radio"/> Dr
<b>First Name</b>					
<b>Surname</b>					
<b>Gender</b>	<input type="radio"/> Male				<input type="radio"/> Female
<b>Birthdate</b>					
<b>Address</b>					
	<b>Postcode</b>				
<b>Home Phone</b>					
<b>Mobile</b>					
<b>Work Phone</b>					
<b>Email Address</b>					
<b>Preferred Form of Contact</b>	<input type="radio"/> Home	<input type="radio"/> Mobile	<input type="radio"/> Work	<input type="radio"/> Email	
<b>Nationality</b>					
<b>Occupation</b>					
<b>My last dental examination was on</b>					
<b>How did you hear about us?</b>					
<input type="radio"/> Internet (Which site?):					
<input type="radio"/> Newspaper/ Magazine (Please specify):					
<input type="radio"/> Live locally					
<input type="radio"/> Walked past					
<input type="radio"/> From a current patient (Please let us know their name):					
<input type="radio"/> Other (Please specify):					

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<b>About* your teeth.</b>		<b>Yes</b>	<b>No</b>
1.	Are you happy with your smile?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Would you like your teeth to look whiter or brighter?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Are your teeth sensitive?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you any teeth you think are unsightly, misshapen or out of line?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Are you concerned you have bad breath?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Do your gums bleed when you floss or brush your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Are you concerned about:	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="radio"/> Old crowns that now do not match your other teeth or have dark lines at the gum?		
	<input type="radio"/> Old or stained fillings that show when you smile?		
	<input type="radio"/> Silver fillings that could be replaced with tooth coloured restorations?		
	<input type="radio"/> Missing teeth you would like to replace?		
8.	Do you suffer from headaches, neck-aches or shoulder pain?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>

If we have missed anything that you are concerned about, please feel free to mention this to your dentist, as he or she would be happy to discuss it with you.

<b>About* your health.</b>		<b>Yes</b>	<b>No</b>
<b>Are you...</b>			
1.	Receiving treatment from a doctor, hospital or clinic?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Taking any pills, medicines or tablets?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Allergic or have reacted adversely to:		
	-Penicillin or any other drug or medicine?	<input type="checkbox"/>	<input type="checkbox"/>
	-Latex or other materials?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Taking any of the following:		
	-Antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>
	-Anticoagulants?	<input type="checkbox"/>	<input type="checkbox"/>
	-Medicine for high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
	-Cortisone (steroids)?	<input type="checkbox"/>	<input type="checkbox"/>
	-Insulin or other medication for diabetes?	<input type="checkbox"/>	<input type="checkbox"/>

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<b>Women only</b>		<b>Yes</b>	<b>No</b>
5.	Is there any possibility that you may be pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Estimated date of delivery			
<b>In the past have you...</b>			
6.	Had any serious illness or operations?		
7.	Had any of the following diseases or problems:	<b>Yes</b>	<b>No</b>
	-Rheumatic fever or rheumatic heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
	-Heart trouble, replacement heart valve, high blood pressure or stroke?	<input type="checkbox"/>	<input type="checkbox"/>
	-Sinus trouble?	<input type="checkbox"/>	<input type="checkbox"/>
	-Asthma?	<input type="checkbox"/>	<input type="checkbox"/>
	-Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
	-Hepatitis or HIV?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Had abnormal bleeding associated with previous extractions, surgery or trauma?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Had any problems with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
	Number per day?		

**Is there anything else that you would like us\* to know?**


**Signature**

**Date**

**Thank you\* for taking the time to answer our questions.  
Please return to - UltraSmile\* 127a Basin Approach  
London E14 7JG or Fax 08452 300 900**

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