Forename:	Surname:
Address:	
	Postcode:
Date of Birth:	
Tel No (Home):	Occupation:
Tel No (Mob):	Email:

Certain medical conditions can affect dental treatment and vice-versa

Have / Do you suffer from :	Yes	No	Do you:	Yes	No
Rheumatic Fever			Smoke		
Diabetes			Take medicines/tablets		
Epilepsy			**Do you have any:**	**Yes**	**No**
Hepatitis			Heart Complaints		
High Blood Pressure			Serious Illnesses		
Excessive Bleeding			**In the last 2 years have you had:**	**Yes**	**No**
Are you:	**Yes**	**No**	Operations		
Pregnant			Steroids		
Breastfeeding			Notes		
On blood thinning medication					
Allergic to ANY Medicines/Tablets					

Name and address of your doctor	Sign *(patient signature)*	Date (1st Visit)
	Sign *(patient signature)*	Date (2nd Visit)
	Sign *(patient signature)*	Date (3rd Visit)
	Sign *(patient signature)*	Date (4th Visit)
	Sign *(patient signature)*	Date (5th Visit)

PTO AND ANSWER QUESTIONS OVERLEAF

Additional notes regarding medical history:

Patient Satisfaction Survey – *please complete below*

1. How did you hear about the practice?

• Just Passing (on main road)	
• Recommended by another patient	
• Internet – please circle which one *www.pennyhilldental.com, www.yell.com*	
• Leaflet distribution through letter box	
• Yellow Pages, Thompson's Local	
• Directory Enquiries, 118247	
• Newspaper Advertisement	
• Other (please specify)	

2. Are you happy with your smile?

• Yes		• No	

3. What would you like to change?

• Tooth discolouration	
• Missing teeth	
• Sensitive teeth	
• Crooked, misaligned teeth	
• Fresher Breath	
• Other	

Thank you for your time