Hoburne
DentalPractice

104 Saffron Drive, Highcliffe, Christchurch, BH23 4TG | (01425) 277245 | www.hoburne-dental.co.uk

Personal Details:

Title & Full name _____ DOB _____

First line of address _____ Postcode _____

What do you want to be called? _____ e.g. Mr Smith/John Smith or John

Day-time tel _____Work tel_____

Mobile_____E-mail _____

Gender _____ Occupation _____

Request for confidential communication:

Please can you indicate your preferred means of contact below. From time to time we may need to contact you to discuss treatment, book or remind you of upcoming appointments. If you are happy for us to do this with another person, please let us know.

	No	Yes		No	Yes
• **Contact me at home**	☐	☐	• **Leave messages on my work voicemail**	☐	☐
• **Contact me via mobile phone**	☐	☐	• **Leave messages on my home voicemail**	☐	☐
• **Text me**	☐	☐	• **Leave messages on my mobile voicemail**	☐	☐
• **Contact me at work**	☐	☐	• **Discuss treatments with another person**	☐	☐
• **Contact me via e-mail**	☐	☐	Name the person _____		

How did you hear about Hoburne Dental Practice?

Internet ☐ Professional Recommendation ☐

Advert ☐ where did you see the advert? _____

Recommended by another website ☐ *which one* _____

Recommended by friends /family ☐ _____ (name)

Other ☐ _____

The data you have submitted will only be used in accordance with the Data Protection Act 2018. Your information will be processed fairly and lawfully and will only be used for business reasons and Information will not be shared, or sold to any third parties. Peter Willy is the Data Controller. Registration Number Z5119663

Confidential Medical History

Doctor's surgery _____

Are you under medical care or taking any prescribed or self-prescribed medication? ☐ Yes ☐ No

Please list any medications here.

Have you been prescribed Steroids in the last year? ☐ Yes ☐ No

Have you ever been prescribed Bisphosphonates (*bone strengthening drugs*) **Orally or intravenously?** ☐ Yes ☐ No

Do you have any Allergies? If so, please specify. _____ ☐ Yes ☐ No

Do you have a DNR or ADRT? If so, please provide a copy ☐ Yes ☐ No

Do you need Antibiotic Cover for dental treatment? ☐ Yes ☐ No

Have you had any of the following? (Please✓ all that apply) ***Please give details***

☐	Joint replacement or other implant	_____
☐	Congenital heart lesion/pacemaker	_____
☐	Jaundice, hepatitis, liver, kidney disease	_____
☐	Heart condition/angina	_____
☐	Infectious diseases	_____
☐	High or low blood pressure or Stroke	_____
☐	Bronchitis, asthma, chest conditions	_____
☐	Prolonged bleeding/bruising problems	_____
☐	Diabetes	_____
☐	A medical warning card	_____
☐	Epilepsy fits, fainting attacks	_____
☐	Arthritis	_____
☐	Hay Fever or Eczema	_____
☐	Any other serious illness	_____
☐	Blood refused when tried to donate	_____

Have you had any ill effects from any of the following? ***(Please ✓ all that apply)***

☐ Antibiotics ☐ Local or general anaesthetic ☐ Dental treatment

☐ Do you think you *may* be pregnant? If so when is the expected delivery date? _____

☐ Do you have problems lying flat?

☐ Have you ever had an operation? (Please specify)_____

☐ Have you ever had a close relative with CJD? (Please specify)_____

Do you smoke? ☐ Yes ☐ No If yes, how many: a day? _____

Do you Vape? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, how many units a week? _____

Completed by ☐ Self ☐ Parent ☐ Guardian

Signature (Patient)	Date	Signature (Dentist)	Date

URN:_____ *(Office use only)*

Dental Information

1 Where was your last practice? _____

2 How long ago was your last appointment (*approximate date*):

Exam: _____ Hygienist:_____ Treatment _____

If 1 = poor and 10 = ideal, I would score my current smile:

1 2 3 4 5 6 7 8 9 10

Please ✓ the following boxes if they apply to you.

I feel self conscious about my teeth when I smile ☐

I wish my teeth were whiter and brighter ☐

I wish my teeth were shaped differently ☐

I don't like the colour of my silver fillings ☐

Some of my teeth are discoloured ☐

I have crowns which don't match my natural teeth ☐

I wish my teeth were straighter ☐

My gums sometimes bleed when I brush them ☐

I am not sure my breath is fresh ☐

Are you anxious about receiving dental treatment ☐

If I could alter my smile, I would most like to change:

Why did you choose Hoburne Dental Practice: