SOE No:	Date Completed:

gentle DENTISTRY EST 1984

YOUR MEDICAL AND DENTAL HISTORY

We would like to offer you a warm welcome to Gentle Dentistry. We are delighted that you have selected our practice to care for your dental health. Please take your time to complete this form carefully, and rest assured that we take your confidentiality seriously. It will be maintained at all times. For information on how we handle your data please see the Privacy notice found on our website or ask a member of the reception team for a printed copy.

Name:	**Title:**
Date of Birth:	
Address:	

Contact Details:	**Regarding future visits with us, may we:**		
Home:	Leave you a voicemail message?	Yes	No
Work:	Leave a message with a family member?	Yes	No
Mobile:	Which number is best to contact you on?		
e-mail:	HOME WORK MOBILE		

Occupation:
Who Should We Contact In An Emergency? Name and Telephone Number:
Doctor's Name and Address:

So that we can deliver our best care for you safely, it is important that we know about your previous and current medical health and your past dental experiences. This means that our approach for you is entirely bespoke, and that we offer you the most appropriate and safe treatment.

ARE YOU:	**Yes**	**No**	Please Give Details
1. Attending or receiving treatment from a doctor, hospital, clinic or specialist?			
2. Taking any **medicines** prescribed by your doctor, including **Aspirin**?			LIST OF MEDICATIONS:
3. Allergic to **Penicillin** or any other drug or medication?			
4. Allergic to **latex** or any other substance/ material?			
5. Likely to be **pregnant**?			
6. Carrying any **medical warning cards**?			

DO YOU:	**Yes**	**No**	Please Give Details
1. Have **hay fever** or **eczema**?			
2. Have **arthritis**?			
3. Have a **pacemaker**?			
4. Have **diabetes**, or does anyone in your family?			
5. **Bruise easily** or have persistent bleeding following injury, tooth extraction or surgery?			
6. Have any **infectious diseases** (including HIV/ Hepatitis/ Cold sores)?			

7. Take, or have you taken **steroids**?			

HAVE YOU:	**Yes**	**No**	Please Give Details
1. Ever been told that you have a **heart problem**, **angina, high/ low blood pressure**, or suffered a **heart attack** or **stroke**?			
2. Had **Rheumatic Fever** or Chorea (St Vitus Dance)?			
3. Ever had any serious **chest conditions**, e.g. bronchitis, COPD or asthma?			
4. Ever had **liver disease** (e.g. jaundice, hepatitis) or **kidney disease**?			
5. Ever had any form of **cancer**?			
6. Ever had any blood tests for **blood related diseases**?			
7. Do you suffer from cold sores?			
8. Had any **fainting attacks**, giddiness, blackouts or **epilepsy**?			
9. If you are prone to **fitting** (a) When was your last fit? (b) How long do they last?			
10. Ever had a reaction to a local or general **anaesthetic**?			
11. Ever had blood refused by the blood transfusion service?			
13. Visited countries affected by the **Ebola** virus in the last 30 days? Or been in contact with anyone who has?			

13. Had **growth hormone** treatment before the mid 1980's?			
14. Had a close relative with Creutzfeldt Jakob Disease **(CJD)**?			

DRINKING:	
How many units of alcohol do you drink per week? *(1 unit = half a pint of lager or a single glass of wine)*	_____ per week

SMOKING AND CHEWING:	**Yes**	**No**	How many per day? How many years?
1. Do you smoke any tobacco products, or have you in the past?			
2. Do you use a vape, or have you in the past?			
3. Do you chew tobacco products now, or have you in the past?			

YOUR DENTAL HISTORY:				
1. Are you experiencing any **pain** or **problems**? *Please give details.*				
2. What would **you** like to be done?				
3. Do you experience pain with:	(a) **Hot or cold?**		Yes	No
	(b) **Sweet things?**		Yes	No
	(c) **Biting?**		Yes	No
4. How **long ago** was your last dental visit, and have you been a **regular** attender?	_____ years		Regular	Irregular
5. Have you ever **worn a brace** to straighten your teeth?	Yes	No	_____ years ago	
6. Does food stick **between** your teeth? *If yes, please give details.*	Yes	No		
7. Are you concerned about **bad breath**?	Yes	No		

YOUR DENTAL HYGIENE ROUTINE AT HOME:			
1. Have you ever seen a **dental hygienist**? *If yes, how long is it since your last visit?*	Yes	No	_____ months/ years
2. Do your gums ever **bleed**? *If yes, please give details.*	Yes	No	
3. Which type of **toothbrush** do you use? *Do you prefer a brand?*	Electric	Manual	
4. Do you use a **toothpaste with Fluoride**, e.g. Colgate Total?	Yes	No	
5. Do you **clean between** your teeth? *Which aids do you use?*	Yes	No	Interdental Brushes Floss/ Tape or Other:
6. Do you use a **mouthwash**? *Please give details.*	Yes	No	

LET US KNOW HOW WE CAN HELP IMPROVE YOUR SMILE?	*Tick*
1. If you think your teeth are too **dark or discoloured**, we can lighten them. This is a simple treatment carried out in surgery and/or at home and can produce amazing results!	
2. **Unsightly or misshapen teeth**. These can be reshaped to make them blend with your other teeth.	
3. Do you have **old crowns that do not match** your other teeth? We can replace them with natural looking porcelain crowns.	
4. Do you have **large or unsightly fillings**? We can make them almost invisible with natural tooth shade porcelain inlays.	
5. **Missing teeth**? We offer personalised solutions.	
6. Do you have a **denture that looks or feels false**? We produce natural looking dentures for an improved appearance and comfort.	
7. Are your **teeth uneven, crowded or out of line**? It is never too late to improve them. We offer practically invisible orthodontic options so that you can have a smile that you are proud of showing off!	
8. Do you have **other concerns** about the appearance of your teeth?	

THE HEALTH OF YOUR JAW JOINTS, MUSCLES AND BITE:		
1. Do you have **regular headaches**?	Yes	No
2. Do you have **neck** or **shoulder pain**?	Yes	No
3. Do you **clench** or **grind** your teeth during the night?	Yes	No
4. Do you **clench** or **grind** your teeth during the day?	Yes	No
5. Are your **jaws tired** when you wake up?	Yes	No
6. Do your **teeth ache** when you wake up?	Yes	No
7. Do you have, or have you ever had, **pain in** your **jaw joints** or the side of your face (in or around the ears)?	Yes	No
8. Do your **jaws click** or **pop**, or have they ever clicked or popped when you open your mouth?	Yes	No
9. Do you experience **difficulty moving** your jaw or opening your mouth?	Yes	No
10. Do you have **difficulty chewing**?	Yes	No

REGULAR HEAD, NECK, SHOULDER OR JAW PAIN: If you have answered 'Yes' to any of the questions above, please tell us:			
1. How often do you experience head, neck or shoulder pain?	_____ times per _____		
2. How long does the pain last for?			
3. Is the pain:	MILD	MODERATE	SEVERE
4. Do you take medication for the pain? *If yes, please give details.*			
5. Where do you have the pain? *Please give details.*			
6. When does the pain occur? *Please give details*.			
6. Have you ever experienced a sharp blow to the head or jaw? *If yes, please give details.*			

8. Do you regularly suffer from: - Earache - Ear infection - Dizziness - Buzzing or noises in your ear - Cracking jaw joints	Yes Yes Yes Yes Yes	No No No No No
9. Have you had previous treatment for jaw, head, neck or shoulder pain? *If yes, please give details.*		
OTHER INFORMATION: Please give any other details that you feel we may need to know about. If you require additional space, please use the back page.		

Statement:

I have provided a medical and personal history which is complete and accurate and recognise that Gentle Dentistry and the treating Clinician will maintain my confidentiality.

- I agree to this information being made available to other healthcare professionals (such as specialist dental colleagues, my GP or a hospital consultant) as necessary.

- I understand that as part of my care the dentist may need to take **photographs** of my full face, mouth and teeth before/ during/ after treatment. I understand that the illustrations will form part of my dental records.

Completed by (*Please circle*):	SELF	PARENT	GUARDIAN
Signature:		**Date:**	

PATIENT PHOTO CONSENT FOR SECONDARY PURPOSES

Where you cannot be identified.
We would like to use anonymised photos of your lips and teeth only for research, training and advertisement purposes.

☐ I am happy for Gentle Dentistry and the dental professional treating me to use anonymised photos of me for research, training and advertisement purposes.

Where you can be identified.
To respect your privacy and to comply with data protection legislation, we require your explicit consent to use identifiable photos for secondary purposes, such as advertising and education.

The dental professional treating you may also use these images for similar secondary purposes, and you can also consent to this. You may revoke your consent for both the practice and the dental professional at any time by contacting the practice or sending a direct message to the dental professional on social media.

Personal Data: photographs and videos of me('images'), first name, social media handle (if applicable/available), type of treatment received (e.g. composite bonding), and information provided in my treatment testimonial.

Declaration

I consent to the following parties to use my personal data as listed below for the selected purposes:

☐ **Gentle Dentistry** ☐ **Dr Daniel Cattell** ☐ **Dr Dimitrios Papalexiou**

Purposes:

☐ Advertising, marketing, promotion, and publicity*

☐ Education and lecturing.

I understand that by providing my consent:

- My personal data, as set out in the purpose, may be used in a variety of media, including printed publications, brochures, websites, e-marketing, posters, banners, advertising, film, and social media.

- Efforts will be made to remove my personal data form existing online and offline publications if I withdraw my consent, but it may still appear in existing publications already in circulation.

I agree to:

- The modifying, cropping, adding or removing from the images at its own discretion and without my prior approval.
- Assigning the practice with the right, title, and interest, the right to bring and defend proceedings, and obtain and retain any relief recovered (including damages or an account of profits) in respect of any infringement or any other cause of action arising from ownership of the images.

Name:	
Signature:	**Date:**