New Patient Questionnaire

STRICTLY CONFIDENTIAL

HDS
HOCKLEY DENTAL SURGERY

PATIENT NAME: DATE OF BIRTH

Dear Patient,

At Hockley Dental Practice we would like to take the time to understand how to treat you in the way you want. The questions below are designed to help us offer you the treatments and therapies you are interested in. Our dentists are constantly educating themselves in new techniques so we can offer you the best possible service.

Previous Dental Experience:

Q. When was the last time you visited the dentist?

Q. Have you had any bad experience with previous treatment in the past? YES ◯ NO ◯

Q. Are you nervous or anxious when visiting the dentist? YES ◯ NO ◯

Q. If so would you be interested in sedation? YES ◯ NO ◯

Q. Is there anything we can do to make your treatment here more comfortable?

Treatments for you:

Please tick if any of the treatments or services below interest you ?

Tooth Whitening ◯	Snoring Treatments ◯
Implants ◯	Mouthguards ◯
Sedation (for nervous patients) ◯	Fine lines & Wrinkle therapies ◯
Treatment for headaches ◯	Smile Makeovers (cosmetic veneers) ◯
	Replacement of worn fillings ◯

Q. Are there any treatments not listed above that you would like ? (e.g. replacement denture, closing gaps etc.)

Q. Where did you hear about us ?

Recommendation (Friends & Family) ◯ Live locally ◯ Advert ◯ Website ◯