

# New Patient Questionnaire

**Patient Name:**

**Date of Birth:**

Dear Patient,

At Hockley Dental Surgery, 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 experiences with previous dental treatment?

Q: Are you nervous or anxious when visiting the dentist?

Q: If yes, would you be interested in sedation?

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

## *Treatments for You:*

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

- |   |  |
|---|--|
| <input type="checkbox"/> Tooth whitening    | <input type="checkbox"/> Mouthguards                     |
| <input type="checkbox"/> Implants           | <input type="checkbox"/> Fine lines & wrinkle treatments |
| <input type="checkbox"/> Sedation           | <input type="checkbox"/> Smile makeovers                 |
| <input type="checkbox"/> Snoring treatments | <input type="checkbox"/> Replacement of worn fillings    |

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

Q: Where did you hear about us?

- |   |                                  |
|---|----------------------------------|
| <input type="checkbox"/> Recommendation | <input type="checkbox"/> Advert  |
| <input type="checkbox"/> Live locally   | <input type="checkbox"/> Website |