belmore
FACIAL AESTHETICS
& DENTAL IMPLANT CLINIC

Patient information and Medical History

Name: Date of Birth:

Address: Post Code:

(We use an SMS & Email reminder system please be sure to include the following details)

Tel: Doctor Name:

Email: Doctor Address:

Mobile:

IRISH DENTISTRY 2017 Awards WINNER Practice of the Year Northern Ireland

Practice of the Year Northern Ireland 2017
Best Dental Team UK & Ireland - 2014, 2012, 2010

16 Belmore Street, Enniskillen,
Co. Fermanagh, BT74 6AA.
Tel: 028 6632 9222 | From ROI: 048 6632 9222
Email: info@belmoredental.co.uk
Web: www.belmoredental.co.uk

Patient Consent

I consent to the use of photographs or video footage for use on the Belmore Dental Implant Clinic website, social media sites, in newsletters and publications as well as for distribution to members:

☐ Full face images ☐ Mouth only images

How did you hear about Belmore Dental

☐ Social Media ☐ Website ☐ From a friend ☐ Magazine/Newspaper
☐ BT/Yellowpages ☐ Golden Pages ☐ Other

Would you like to receive information on our upcoming

☐ Events ☐ Special Offers ☐ Newsletters

We take your privacy seriously. From time to time we would like to contact you with details of other services that we provide or introduce, such as additional clinics or introductory treatment offers. In order to do this we might need to pass your details to third-party communication companies who will deliver these messages to you and use your details solely for the purpose of delivering this content. We do not pass your details on to other parties for unsolicited marketing purposes.

I consent for my details to be used for the purposes outlined above ☐ Yes ☐ No

Smile Check

Please tick the relevant boxes to help us know your current dental concerns.

☐ Would you like your teeth to look whiter or brighter?
☐ Are your teeth sensitive?
☐ Have you any teeth you think are unsightly, mis-shapen or out of line?
☐ Do you have any old crowns that now do not match your other teeth or have dark lines at the gums?
☐ Do you have old or stained fillings that show when you smile?
☐ Do you have any silver fillings that you would like replacing with tooth coloured mercury free restorations so that they blend in better?
☐ Do you have any missing teeth that you would like replacing to improve your smile and your bite?
☐ Do you have an old, worn denture, or an NHS denture that looks false and feels false?
☐ Are your teeth stained or your gums red and swollen?
☐ Do your gums bleed when brushing?
☐ Do you get a bad taste in your mouth or around some teeth?
☐ Are you concerned that you may have bad breath?
☐ Do you play contact sports without wearing a gum shield to protect your teeth, smile and your bite?

Have you ever suffered from or had any of the following

Heart

1. Heart problems/heart murmur ☐ Yes ☐ No
2. Rheumatic fever ☐ Yes ☐ No
3. High blood pressure ☐ Yes ☐ No
4. Stroke ☐ Yes ☐ No
5. Angina ☐ Yes ☐ No
6. Pacemaker Fitter ☐ Yes ☐ No
7. Heart Surgery ☐ Yes ☐ No
   Please specify
8. Alcohol Drinker ☐ Yes ☐ No
   Units per week
   Other heart condition please specify

Chest

9. Asthma ☐ Yes ☐ No
10. Bronchitis ☐ Yes ☐ No
11. Emphysema ☐ Yes ☐ No
12. Pneumonia ☐ Yes ☐ No
13. Chest Surgery ☐ Yes ☐ No
14. Smoker ☐ Yes ☐ No
    How Many Per Day
15. Previous Smoker ☐ Yes ☐ No

Other chest condition please specify

Blood

16. Blood disorders or prolonged bleeding ☐ Yes ☐ No
17. Hepatitis (Type_____) ☐ Yes ☐ No
18. HIV ☐ Yes ☐ No
19. Anaemia ☐ Yes ☐ No
20. Haemophilia ☐ Yes ☐ No
21. Other blood condition please specify

Other

22. Arthritis ☐ Yes ☐ No
23. Diabetes ☐ Yes ☐ No
24. Sinus problems ☐ Yes ☐ No
25. Kidney disease ☐ Yes ☐ No
26. Liver disease ☐ Yes ☐ No
27. Epilepsy, convulsions ☐ Yes ☐ No
28. Cancer ☐ Yes ☐ No

Other condition please specify

Allergies

29. Penicillin ☐ Yes ☐ No
30. Hay Fever ☐ Yes ☐ No
31. Aspirin ☐ Yes ☐ No
32. Latex ☐ Yes ☐ No

Other Allergic Condition please specify

Warnings

33. Cold Sores ☐ Yes ☐ No
34. Do Not Recline ☐ Yes ☐ No
35. Artificial Joint ☐ Yes ☐ No
36. Warning Card ☐ Yes ☐ No
37. Osteoporosis ☐ Yes ☐ No
    If yes do you take Bisphosphonates ☐ Yes ☐ No
    Oral ☐ IV ☐
38. Have you received or are you currently receiving psychiatric treatment ☐ Yes ☐ No

Are you:

39. Being treated for any Other illness ☐ Yes ☐ No
40. Female – Pregnant ☐ Yes ☐ No
41. Male – Prostate disorders ☐ Yes ☐ No

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is your immediate concern?

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Sleep Assessment

Do you snore ☐ Yes ☐ No
Do you suffer from sleep apnoea ☐ Yes ☐ No
Do you wake up feeling tired ☐ Yes ☐ No

Bite and Jaw Joint

Do you / would you have any problems chewing gum
☐ Yes ☐ No

Do you clench or grind your teeth during the day?
☐ Yes ☐ No

Have you been made aware of clenching or grinding your teeth at night? ☐ Yes ☐ No

Are your jaws or teeth tired when you awaken?
☐ Yes ☐ No

Do you suffer from chronic neck or headaches of any kind? ☐ Yes ☐ No

Do you experience chronic neck or shoulder pain?
☐ Yes ☐ No

Have you ever had pain in your jaw joints, the side of your face, or around your ear ☐ Yes ☐ No

Have your jaws ever clicked or popped when you open your mouth? ☐ Yes ☐ No

Have you ever experienced difficulty moving your jaw or opening your mouth wide? ☐ Yes ☐ No

Do you chew on only one side of your mouth?
☐ Yes ☐ No

Please list any current medication

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Skin Care

Which skin type would you say most closely represents your own?

☐ Sensitive ☐ Dry ☐ Normal ☐ Combination ☐ Oil ☐ Dehydrated

Do you have any of the following skin complaints

☐ Acne ☐ Rosacea ☐ Pigmentation ☐ Skin Aging

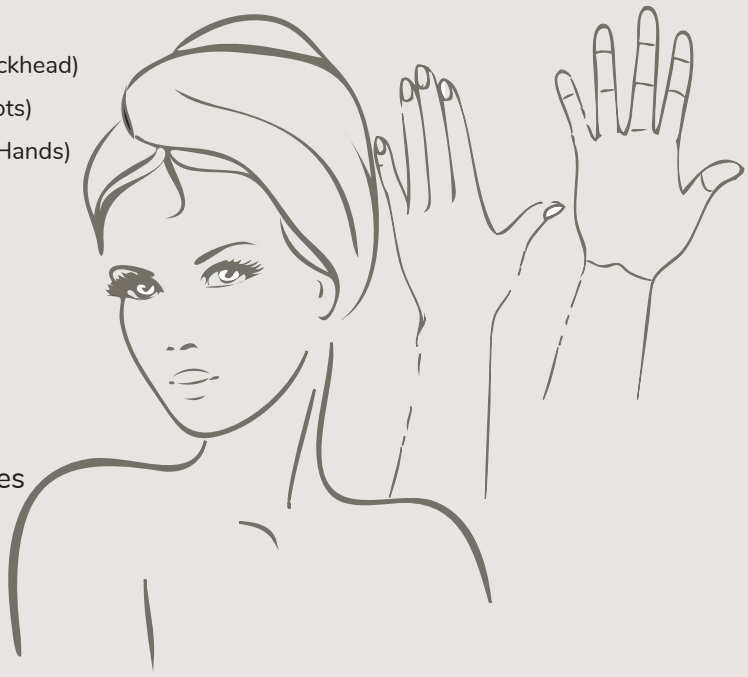
Please Circle Any Areas of Concern

AGEING / DRY

- ☐ Fine Lines
- ☐ Wrinkles
- ☐ Decreased Volume
- ☐ Loss Of Elasticity
- ☐ Glycation (criss crossed lines)
- ☐ Flaky Skin
- ☐ Dehydration
- ☐ Dryness

OILY / ACNE

- ☐ Comedones (Blackhead)
- ☐ Papule's (Red Spots)
- ☐ Pustules (Yellow Hands)
- ☐ Cysts
- ☐ Scarring
- ☐ Sallow Skin
- ☐ Oiliness
- ☐ Open Pores



PIGMENTATION

- ☐ Hyper Pigmentation (Brown Spots)
- ☐ Hypo Pigmentation (White Spots)
- ☐ Uneven Skin Tone
- ☐ Maccules (Freckles)
- ☐ Moles
- ☐ Undiagnosed Skin Lesions

ROSACEA

- ☐ Broken Capillaries
- ☐ Inflammation
- ☐ Thread Veins
- ☐ Redness
- ☐ Flushing
- ☐ Compromised Lipid Barrier

Which treatments offered at Belmore Dental Implant & Facial Clinic are you most interested in?

☐ Wrinkle Reduction Injections
☐ Threadlift 'Facelift'
☐ Sweat Reduction Injections
☐ Dermal Fillers
☐ Chemical Facial Peel
☐ Mesotherapy PRGF
☐ Professional Skin Care Products

What are your immediate areas of concern?

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When did you first notice your skin condition?

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Do you notice it worse at any time of the day/month/year?

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What is your current have a skincare regime AM & PM? What skin care products are you using

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Do you use a sunscreen? ☐ Yes ☐ No

Do you exfoliate weekly? ☐ Yes ☐ No

Have you ever suffered from or had any of the following?

Melasma? (pigmentary change of the face)	☐ Yes	☐ No
Keloids (hypertrophic scarring)?	☐ Yes	☐ No
Moles?	☐ Yes	☐ No
Sunburn?	☐ Yes	☐ No
Cuts/Abrasions?	☐ Yes	☐ No
Contact Dermatitis?	☐ Yes	☐ No
Skin Disease (e.g herpes or acne)?	☐ Yes	☐ No
Glaucoma/Cataract?	☐ Yes	☐ No
Bell's/Facial Palsy?	☐ Yes	☐ No

Are You Currently taking steroids or anti-coagulant on a daily basis?	☐ Yes	☐ No
Do you bruise easily?	☐ Yes	☐ No
Have you had an allergic reaction to any cosmetic product?	☐ Yes	☐ No
Have you been treated with any cosmetic products before? (Botox, Dermal Fillers etc)	☐ Yes	☐ No
Do you suffer from Myasthenia Gravis or Eaton Lambert Syndrome?	☐ Yes	☐ No