Health Questionnaire

(Private & Confidential)

So we can ensure we are looking after your needs, please complete the following:

(MR/MRS/MISS/MS/DR) ______________________ FIRST NAME _______________________________

SURNAME: ________________________________ DATE OF BIRTH: ____________________________

ADDRESS: ____

____ POST CODE: ______________________

PRIVATE PHONE: _________________________ BUSINESS PHONE: ___________________________

MOBILE PHONE: ____

EMAIL: ____

OCCUPATION: ____

PERSON RESPOSIBLE FOR FEES (IF NOT SELF) ____

RECOMMENDED BY: ____

PURPOSE OF VISIT: ____

DENTAL INSURANCE COMPANY: ____

Have you had any of the following?

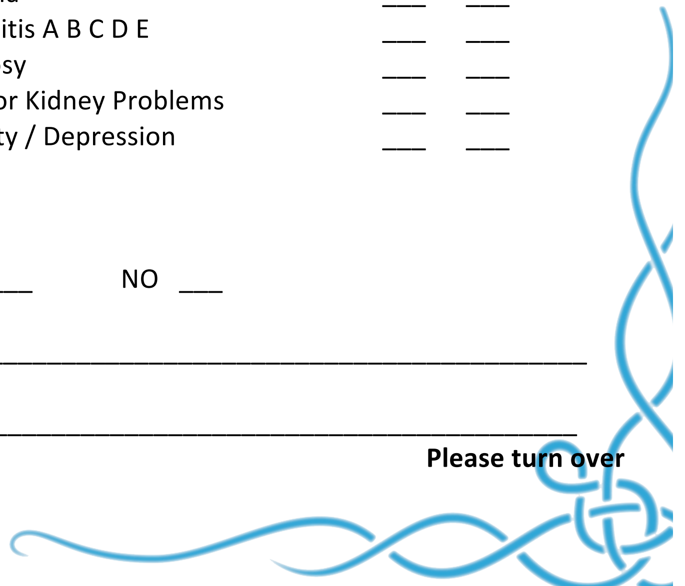
	YES	NO		YES	NO
Heart Problems	___	___	Allergies to Anaesthetics	___	___
Blood Pressure	___	___	Allergies to Penicillin	___	___
Artificial Joints	___	___	Allergies to Medications	___	___
Rheumatic Fever	___	___	Allergies to Latex	___	___
Circulatory Problems	___	___	Anemia or other Blood Disorders	___	___
Radiation Treatment	___	___	Diabetes	___	___
Excessive Bleeding	___	___	Asthma	___	___
Excessive Bruising	___	___	Hepatitis A B C D E	___	___
Ulcers (stomach)	___	___	Epilepsy	___	___
Sinus Trouble	___	___	Liver or Kidney Problems	___	___
Tumour History	___	___	Anxiety / Depression	___	___
Blood Pressure	HIGH	LOW			

Are you currently taking any drugs or Medications? Yes ___ NO ___

If Yes', please list: ____

Name of your physician: ____

Please turn over



Have you had any of the following?

	YES	NO
Does your jaw 'click' or hurt?	___	___
Do you feel you grind your teeth?	___	___
Have you ever had orthodontic treatment?	___	___
Do you wear a dental night guard?	___	___
Have you ever had a periodontal (gum) treatment?	___	___
Have you ever had your bite adjusted?	___	___
Do you bite your lips or cheeks often?	___	___
Do you smoke?	___	___
Do you think you have occasional bad breath?	___	___
Do your gums ever bleed when you clean your teeth?	___	___
Do you experience sensitivity with hot / cold?	___	___
Do your teeth ever hurt when you bite hard?	___	___
Does floss ever tear between your teeth?	___	___
Does food get jammed between your teeth?	___	___
Any other dental specialist treatment in the past?	___	___
Is there anything else you would like us to know?	___	___

Other notes: ____

Are you Pregnant? YES NO If yes, what is your due date? _________________________________

How long since your last dental appointment? ______________________
Previous dental x rays were taken: ☐ Less than a year ago ☐ Longer than a year ago

FOR YOUR COMFORT: Many people are still nervous about coming to the dentist. Please circle the number that indicates your present level of apprehension so we can cater dental treatment for you.

Completely at Ease 0 1 2 3 4 5 6 7 8 9 10 **Petrified**

Consent for treatment

1. I hereby authorize the dentist of designated team to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.
2. Upon diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anaesthetics', sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I agree to pay for collection costs, legal fees, debt collection costs to be added to my account to recover any monies owing by me.
5. I authorize that this data may be reviewed by team members of the dental practice.

In signing this I acknowledge that this represents an accurate medical and dental history and I will advise my dentist of any changes to my medical/dental history.

Patient's signature____ _ Date: _________________________

Parent/Responsible Party's Signature: ______________________________ Relationship to Patient: __________

- END -