CONFIDENTIAL PATIENT QUESTIONNAIRE

This provides the dentist with important information required for your Dental treatment and Oral Health Care.

Name:			
	Surname	First Names	Dr / Mr / Mrs / Miss / Ms

Home Address: _____ Date of Birth: _____/_____/_____

_____ Home Phone: _____

_____

_____ Mobile Phone: _____

_____

_____ Work Phone: _____

Occupation: _____

E-mail Address: _____

Details of person to contact in an emergency:

Name: _____ Phone Number: _____

Medical Doctors Name: _____ Phone (If known): _____

MEDICAL HISTORY **Yes/No**

1. Are you receiving any medical treatment at the present time?
   Details: _____
2. Have you been a patient in hospital during the past two years?
   Reason: _____
3. Have you taken any medicine tablets, capsules or drugs during the past year?
   Details: _____
4. Have you experienced any allergies or unusual effects from any tablets,drugs,injections or anaesthetic?
   Details: _____
5. Are you, or have you been, under the care of a doctor during the past two years?
   Reason: _____
6. Have you ever had any of the following? If so, please tick as appropriate.

	Rheumatic Fever		Epilepsy
	Heart Trouble		Anaemia
	High Blood Pressure		Diabetes
	Asthma		Kidney Trouble
	Arthritis		Gastric Problems
	Hepatitis - Specify type A, B, C		Cold Sores
	Bronchitis or Chest Problems		Depressive Illness
	Severe Headaches		Drug Dependence

7. Have you had any prosthetic surgery? (eg Heart Valve or Hip Replacement)
   Details: _____
8. Are you HIV positive?
9. Are you at risk to HIV exposure?
10. May we use photographs and x-rays for education/marketing purposes?
11. Ladies only: Are you pregnant? If so, how many months: _____

Referred By:

	Yellow Pages		Another patient/friend (Name) _____
	Web Site		Mail Drop
	Street Sign		Other (Please specify) _____
	Review from the web		

I consent to whatever dental procedures and anaesthetics are necessary for the treatment.
I also agree to assume full financial responsibility for all treatment rendered.

Signed: Patient/Parent/Guardian _____ Date: _____

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P T O ...

DENTAL HISTORY

1. Do you have any present dental complaints? Yes No What? _____
2. When was your last full mouth x-ray taken? _____
3. When was your last cleaning? _____
4. Have you ever been instructed in the prevention of decay? _____
5. Have you ever been instructed in caring for your gums? _____

6. Do you like the appearance of your teeth; you smile? Yes No
   If not, explain _____
   _____

7. Are your teeth all in alignment (straight)? Yes No
   If not, explain _____
   _____

8. Do you have spaces that you don't like? Yes No
   If yes, explain _____
   _____

9. Do you like the colour of your teeth? Yes No
   If not, explain _____
   _____

10. Do you like the shape of your teeth? Yes No
    If not, explain _____
    _____

11. Are your teeth…
    Chipped? _____ Protruding? _____ Hidden? _____
    _____

12. Are your teeth wearing on the biting surface? Yes No
    If yes, explain _____
    _____

13. Are there old fillings or dental work you don't like looking at? Yes No
    If yes, explain _____
    _____

14. What would you like to change most in the appearance of your teeth?

15. How would you like your teeth to look?