



Patient Questionnaire (Confidential)

This Questionnaire provides the information your dentist needs for your dental treatment and oral health care.

Preferred title: MR / MRS / MS / MISS / MAST / DR / PROF

First Name: Surname:

Postal Address:

Email address:

Telephone: Home

Mob:

Work:

How would you prefer to be reminded of your appointment? Text / Email / Phone Call

Date of Birth:

Occupation: Medical Practitioner:

If you are under 16, please give name and address of parent / guardian:

In the unlikely case of an emergency, best contact details (name & mobile):

In order to provide the best and safest dental treatment your dentist needs to know of any medical problems which may affect your treatment.

Do you have an existing illness: YES NO If yes, please explain:

| | | | | | | | |
|-----------------|----------------------|------|--------------------------|-----|--------------------------|--------|--------------------------|
| Cardiovascular: | Heart Disease | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | | |
| | Heart Murmur | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | | |
| | Rheumatic Fever | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | | |
| | Open Heart Surgery | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | | |
| | Blood Pressure | HIGH | <input type="checkbox"/> | LOW | <input type="checkbox"/> | NORMAL | <input type="checkbox"/> |
| | Stroke | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | | |
| Respiratory: | Asthma | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | | |
| | Chest & Lung Disease | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | | |
| | Sinus | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | | |
| Other: | Hayfever | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | | |
| | Epilepsy | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | | |
| | Diabetes | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | | |
| | Kidney Problems | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | | |
| | Gastric Problems | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | | |
| | Radiotherapy | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | | |

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Do you smoke: YES NO

Are you taking any tablets, medicines, pills or drugs? YES NO
If yes please list:

Have you ever had any allergies to medicines, or other substances (such as latex or foods)
If yes please list:

Do you have an artificial or prosthetic joint? YES NO

Have you ever experienced excessive bleeding or bruising from dental treatment or at any other
time? YES NO

Have you ever had (contact with) HIV virus YES NO
Hepatitis B virus YES NO
Hepatitis C virus YES NO

Have you ever had an unfavorable reaction to an anaesthetic? YES NO

Are there any health matters you need to discuss with the dentist? YES NO

WOMEN: Are you pregnant? If so how many weeks?

Are you currently suffering dental pain? YES NO

Do you currently have any issues with your teeth/tooth/gums or jaw? If yes please
explain:

YES NO

Are you happy with the appearance of your teeth? YES NO

When did you last visit the dentist?

How did you hear about Remarkables Dental?
Yellow Pages / Website / Friend/Family / Driving Past Surgery, Other:

I agree to assume full financial responsibility for all dental treatment rendered. Payment is due on day of treatment (unless prior arrangement has been made) Accounts not paid within 30 days will be liable for collection costs.

A \$50 fee will be charged for any late cancellations less than 24 hour before the appointment or for a missed appointment.

I agree that the information I have given on this form is true and correct to the best of my knowledge.

Signature:

Date:

