DENTAL QUESTIONNAIRE

WELCOME TO OUR PRACTICE...

Please answer these questions as completely as possible. It will greatly assist us to provide the best dental treatment for you.

NAME (Mr / Mrs / Miss / Ms / Other) ..... (FIRST NAMES) ..... (FAMILY NAME)

ADDRESS ..... POSTCODE .....

DATE OF BIRTH ..... PHONE (HOME) ..... PHONE (WORK) .....

EMAIL ..... MOBILE .....

OCCUPATION ..... EMPLOYER .....

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT .....

WHOM MAY WE THANK FOR RECOMMENDING YOU TO OUR PRACTICE? .....

WHICH HEALTH FUND DO YOU BELONG TO? .....

Please indicate if you have ever had any of the following:	Y	N
Rheumatic fever	☐	☐
Any heart (cardiac) complaint / treatment	☐	☐
A cardiac pacemaker	☐	☐
High or low blood pressure	☐	☐
Anti-coagulant (blood thinning) treatment	☐	☐
Blood disorders	☐	☐
Excessive bruising or bleeding	☐	☐
Osteoporosis or low bone density	☐	☐
Diabetes or family history of diabetes	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Joint replacement surgery	☐	☐
Neck / jaw or shoulder damage or pain	☐	☐
Epilepsy (Fits)	☐	☐
Thyroid disease (including goitre)	☐	☐
Tuberculosis (TB)	☐	☐
Asthma / bronchitis / lung conditions	☐	☐
Any nervous system disorder	☐	☐
Gastric ulcer	☐	☐
Radiation (x-ray) therapy	☐	☐
Allergy or reaction to any medicine (including penicillin or other antibiotic)	☐	☐
Allergy to any foods, chemical or substance (such as chlorine, latex, antiseptics)	☐	☐
Transplanted organ or bone marrow	☐	☐
Do you smoke?	☐	☐
What do you smoke? (Cigarettes / cigars / pipe / other)		
If yes, for how long? ..... How much do you smoke? ..... per day		
Have you ever required treatment for smoking related diseases or conditions?	☐	☐
Do you suffer from any illness or carry any infectious disease?	☐	☐
FEMALES: Are you pregnant?	☐	☐
If so, when are you due?		
Are you breastfeeding?	☐	☐

MEDICAL QUESTIONNAIRE - PRIVATE AND CONFIDENTIAL

The state of your health may have a very significant effect on your dental care. Please answer these questions fully or discuss them with your dentist.

	Y	N
• I have private and confidential medical matters which I wish to discuss with the dentist	☐	☐
• Are you receiving any medical treatment at present?	☐	☐
• Name of your medical practitioner / specialist		
• Have you ever been in hospital?	☐	☐
• Please list any medicines you are taking including dosage (including aspirin, oral contraceptive, HRT, herbal, naturopathic, cortisone / steroids, Warfarin / Heparin, (blood thinning) medicines or 'over the counter' remedies)		

SMILE EVALUATION

If you would be kind enough to answer the questions below it would greatly help us to help you.

	Y	N
Do you like the appearance of your teeth?	☐	☐
Are your teeth all in alignment?	☐	☐
Do you have spaces that you don't like?	☐	☐
Do you like the colour of your teeth?	☐	☐
Do you like the shape of your teeth?	☐	☐
Are your teeth chipped, protruding or hidden?	☐	☐
Are there old fillings or dental work that you don't like looking at?	☐	☐

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

.....

.....

In signing this form I acknowledge that this represents an accurate medical history. I will advise my dentist of any changes to my medical history in the future. I understand that all medical details will be treated with complete professional confidentiality.

SIGNED ..... DATE .....

(PARENT OR GUARDIAN IF UNDER 18 YEARS)

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EXCELLENCE IN DENTAL CARE