

Patients Dental and Medical Questionnaire

Mr / Mrs / Ms / Miss (Please Circle)

Full Name. _____ D.O.B (dd/mm/yy) _____

House/Flat No. _____ Street _____

_____ City _____ Postcode _____

Contact numbers Home _____ Mobile _____

Email Address _____ @ _____

Occupation _____ Wk Phone no _____

Company Name _____

Work Address _____

Postcode _____

Referred by _____ (If another patient please state name)

When did you last visit the Dentist? _____ Hygienist? _____

To help us provide the best possible treatment, dependent upon your needs, we would appreciate if you could indicate below which treatments interest you,

(Please tick the following)

- Treatment of pain only.
- Regular check ups
- Regular hygiene for maintenance of healthy gums
- Cosmetic treatment
- Whitening of your teeth
- Implants (replacement of missing teeth)
- White fillings
- Other _____

How would you prefer to be contacted by us?

(Please tick one box for recalls and one box for confirmation)

Recall Examinations	<input type="checkbox"/> Email	<input type="checkbox"/> Letter
Confirmation of Appointment	<input type="checkbox"/> Email	<input type="checkbox"/> Phone Call

Medical History Update.

Do you have a history of, or ever suffered from the following? Please only tick those that apply.

<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Chest Problems
<input type="checkbox"/> Hayfever	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anaemia
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Giddiness	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Other	<input type="checkbox"/> Allergies

Other information _____

Have you ever had a bad reaction to general or local anaesthetic? _____

Are you under care of a doctor at present? If yes, please give details _____

Are you currently taking any medication? If yes, please give details _____

Are you Pregnant? _____ Expected Date _____

Are you allergic to any drugs? _____

Signature..... Date