



Family Name: _____ First Name: _____
Date of Birth: _____ Occupation: _____
Address: _____
Telephone Numbers: Home: () _____ Work: () _____ Mobile: _____
E-mail address (we can e-mail appointment reminders): _____
What is the best way for us to contact you? Please underline: Home ph Work ph Mobile E-mail Post SMS
Name of your GP: _____
If under 20 - Name & address of parent/guardian: _____

CONFIDENTIAL HEALTH QUESTIONNAIRE

In order to provide the best & safest dental treatment & oral health care, we need to know of any medical problems which may affect your treatment.

- 1. Are you receiving any medical treatment at the present time? Yes/No
If yes for what: _____
- 2. Have you ever been in hospital recently, or for anything serious? Yes/No
If Yes for what: _____
- 3. Have you ever had any of the following? (please tick box)
Rheumatic Fever Epilepsy
Heart Trouble Anemia
High Blood Pressure Diabetes
Asthma Kidney Trouble
Arthritis Gastric Problems
Hepatitis - A,B,C Cold Sores
Bronchitis or Chest Problems Depressive Illnesses ..
Severe Headaches Drug Dependence
Bleeding Problems
- 4. Are you taking any tablets, capsules, medicines or drugs? Yes / No
If yes please list: _____
- 5. Have you any allergies to medicines that you are aware of? Yes / No
If yes please list: _____
- 6. Do you have a prosthetic or artificial joint or heart valve? Yes / No
If yes when was this placed _____
- 7. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? Yes / No
- 8. Have you ever had any contact with the AIDS virus or Hepatitis B virus? Yes / No
- 9. Have you ever had a reaction to an anaesthetic? Yes / No
- 10. Women: Are you pregnant now? Yes / No Months Due Date: / /
- 11. Are there any other aspects concerning your health that you think we should know about?

Reason for attending today: _____
Date of last dental visit: _____ Last dental cleaning: _____ Last full mouth X-Rays: _____
How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
What other aids do you use (Interdental brushes, toothpicks, etc.)?

HAVE YOU EVER HAD:

Orthodontic Treatment Yes / No
Oral Surgery Yes / No
Specialist gum treatment Yes / No
A grinding Splint Yes / No
A serious injury to the mouth or head .. Yes / No

ARE ANY OF YOUR TEETH SENSITIVE TO?

Hot or cold Yes / No
Sweet Yes / No
Biting or chewing Yes / No

HAVE YOU NOTICED:

Any mouth odours or bad taste Yes / No
Your gums bleeding Yes / No

DO YOU:

Clench or grind your teeth regularly Yes / No
Have tired jaws, especially in the morning Yes / No
Smoke/chew tobacco Yes / No

HAVE YOU EXPERIENCED:

Clicking or popping in the jaw Yes / No
Difficulty in opening or closing the mouth Yes / No
Difficulty chewing on either side of the mouth Yes / No

Are there any areas where food gets trapped after meals? Yes / No
Do you feel nervous about having dental treatment? Yes / No
If so what is your biggest concern? _____
How did you hear about us? Please indicate e.g. Yellow pages (book), online yellow, signage, website, search engine, referral from family or friend (please name), other: _____
Is another member of your family a patient at our office? Yes / No
Name: _____ Relationship: _____
Person to contact In Case of Emergency: _____ Phone: _____
Is there anything else about having dental treatment that you would like us to know? :

Signed by: Patient/Parent/Guardian: _____ Date: / /

Please let us know if you are unable to attend to give us time to book someone else into your time slot. For appointments under 1 hour long a charge of \$25 per 15 minutes will be made for cancellations made under 24 hours prior to your appointment time or failed appointments. For appointments longer than 1 hour a charge of \$25 per 15 minutes will be made for cancellations made under 48 hours prior to your appointment time or failed appointments.
We are always happy to provide you with written or verbal estimates on request, for all, or part of your proposed treatment plan. In accepting services at Hobsonville Point Dental, a word about our credit terms – Please note accounts are payable after each appointment. If an account is not paid within 30 days after the due date, our debt recovery agency may charge you a fee equal to 25 % of the unpaid portion of the price & other legal & recovery costs not covered by the fee, but not less than \$25. The account may also be recorded on the credit information database held by Baycorp Business Information Services. Interest at 2% monthly and bank costs, will be charged on any overdue payments and uncleared cheques.

Data entry checked by:

Exact:Medical History/Contacts/Medical History