Health History

So we can ensure we are looking after your needs, please review and complete the following questionnaire:

Surname: (Mr/ Mrs/ Miss/ Ms/ Dr):	First name:
Date of birth:	Address:
Postcode:	Home phone:
Work phone:	Mobile:
Email:	Occupation:
Name of person responsible for fees, if not self:	Address:

Recommended by: _____

Purpose of visit: _____

Is another member of your family a patient at our office: ❍ Yes ❍ No

Have you had any of the following?

Heart Problems	❍ Yes	Allergies to anaesthetics	❍ Yes
Blood pressure	❍ Yes	Allergies to penicillin	❍ Yes
Artificial joints	❍ Yes	Allergies to medication	❍ Yes
Rheumatic fever	❍ Yes	Allergies to latex	❍ Yes
Circulatory problems	❍ Yes	Anaemia or blood disorders	❍ Yes
Radiation treatment	❍ Yes	Diabetes	❍ Yes
Excessive bleeding	❍ Yes	Asthma	❍ Yes
Excessive bruising	❍ Yes	Hepatitis A B C D E	❍ Yes
Ulcers (stomach)	❍ Yes	Epilepsy	❍ Yes
Sinus	❍ Yes	Liver problems	❍ Yes
Tumour history	❍ Yes	Kidney problems	❍ Yes

Are you currently taking any medications? ❍ Yes ❍ No

If yes, please list _____

Have you had any of the following problems?

Does you jaw click or hurt?	❍ Yes
Do you smoke?	❍ Yes
Do you feel you grind your teeth?	❍ Yes
Do you have occasional bad breath?	❍ Yes
Have you ever had orthodontic treatment?	❍ Yes
Do your gums ever bleed when you brush your teeth?	❍ Yes
Do you wear a night guard?	❍ Yes
Do you experience sensitivity to hot/cold?	❍ Yes
Have you ever had gum disease?	❍ Yes
Does floss ever tear between your teeth?	❍ Yes
Have you ever had your bite adjusted?	❍ Yes
Does food get jammed between your teeth?	❍ Yes
Do you bite you lips or cheek often?	❍ Yes
Do you teeth ever hurt when you bite hard?	❍ Yes

Other notes

_____

_____

Name of your physician _____

Address_____

Phone number _____

Are you Pregnant? ❍ Yes If yes, when are you due? _____

How long since your last dental appointment? _____

How often do you have dental examinations? _____

Previous dental x-rays taken ❍ Less than a year ago ❍ Longer than a year

Consent for treatment I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anaesthetics', sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I authorise that this data may be reviewed by team members of the dental practice.

Patient signature: _____Date: _____

Parent/ responsible party's signature: _____

Relationship to patient: _____

(WE EXPECT & APPRECIATE PAYMENT AT TIME OF SERVICE)