Patient Questionnaire (Confidential)

Preferred Title:
MR/MRS/MISS/MS/DR/PROF (surname) (first names)

Address

Email Address(es)

Telephone: (home) (work) (mobile)

Date of birth: Occupation:

When did you last visit a dentist? Name of your last dentist?

How did you hear of this practice?

Name of your doctor/GP:

Do you smoke? Yes No

Do you prefer: ☐ Amalgam (silver) fillings ☐ Composite (white, non-metal) fillings, if suitable
☐ No preference, guided by dentist ☐ I wish to discuss this with the dentist

In order to provide the best and safest dental treatment, your dentist needs to know of any medical problems which may affect your treatment. Have you ever had any of the following? (please tick):

Cardiovascular:			Respiratory:			Other:		
Heart Murmur	Yes	☐ No	Asthma	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Chest & lung disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Open heart surgery	☐ Yes	☐ No	Sinus/hay fever	☐ Yes	☐ No	Kidney problems	☐ Yes	☐ No
High blood pressure	☐ Yes	No				Gastric problems	☐ Yes	☐ No
Stroke	☐ Yes	☐ No				Depressive illness	☐ Yes	☐ No
						Radiotherapy	☐ Yes	☐ No
						Osteoporosis	☐ Yes	☐ No

Are you taking any tablets, medicines, pills or drugs? If yes, please list:

Have you ever had any allergies to medicines, or other substances (such as latex)? If so, 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 unfavourable reaction to an anaesthetic? Yes ☐ No ☐

Women: Are you pregnant now? If so, how many weeks?

Are there any other health matters you need to talk to the dentist about? ☐ Yes ☐ No

Although rare, accidental injury to staff can occur during handling of used instruments. If this happens during the course of your treatment, our practice requires both patient and staff member to undertake a blood test. Do you agree to a confidential blood test? ☐ Yes ☐ No ☐ I wish to discuss this with the dentist

I confirm that the information written above is true and correct to the best of my knowledge.

Signed by: Patient/Parent/Guardian ______________________________ Date ____________________

Please note: Payment is due at the end of your appointment. Unpaid amounts may incur collection fees and penalties.