CONFIDENTIAL PATIENT QUESTIONNAIRE

It I important this form is filled out in full as it provides the dentist with vital information required for your dental treatment. By signing this form you are giving consent to be examined by the dentist.

Title:…… **FULL Name**:…… **DOB**:……..

Home Address: …… **Home Phone No**. ……

…… **Mobile No**. ……

…… **Work No**.: ……

Postcode: …… **Occupation:** ……

Email: ……

Details of person to contact in an emergency:-

Name:…… Relationship:…… Phone No: ……

Medical History – Please fill out this section in full as this may affect your dental treatment

Doctors Name:…… Surgery: …… Phone No: ……

Are you receiving any medical treatment or taking any prescription drugs at the present time? **Y/N**

Give Details:……

Have you received any medical treatment or taking prescription drugs/recreational drugs in the past 2 years? **Y /N**

Give Details:……

Have you experiences any allergies/unusual effects from drugs, injections or anaesthetic? **Y /N**

Give Details:……

Have you ever had or do you suffer from any of the following? Please tick as appropriate and give details below.

Rheumatic Fever		Anaemia		Arthritis		Depressive Illness		Kidney Trouble	
Drug Dependence		Cold Sores		Migraine		High Blood Pressure		Hepatitis A/B/C	
Bronchitis/Chest problems		Asthma		Diabetes		Epilepsy		Heart Trouble	

Details:……

Are you HIV positive? Y /N

Do you smoke/Chew tobacco Y /N How many daily? ……

Do you drink alcohol Y/N How many units weekly? ……

WOMEN: Are you pregnant? Y /N Due Date: ……

Dental History – Please fill out this section in full as this may affect your dental treatment.

Name of last Dentist:…… Surgery: …….. Phone No. ……

Approx Date of last dental visit: …… Do you have dental pain at present?……

Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? Y/N

Do you become anxious or uncomfortable when having dental treatment? Y /N

- **Do you like your smile? Y /N**
- **Are you happy with the colour of your teeth? Y /N**
- **Would you like to replace your metal fillings for white ones? Y/N**

Signed: Patient/Parent/Guardian…… Date: ……

Signed dentist…… Date: ……

How Did you hear about us?

Yellow Pages ……

Street sign ……

Referred by friend (name)

……

Other (Specify) ……