REMARKABLES DENTAL

Patient Questionnaire (Confidential)

This Questionnaire provides the information your dentist needs for your dental treatment and oral health care.

Preferred title: MR / MRS / MISS / MS / DR / PROF

First Name: Surname:

Postal Address:

Email address:

Telephone: Home Mob: Work:

If you would like to be on our recall list, how would you like to be contacted?

Date of Birth:

Occupation: Medical Practitioner:

If you are under 16 please give name and address of parent / guardian:

In the unlikely case of an emergency, best contact details:

In order to provide the best and safest dental treatment your dentist needs to know of any medical problems which may affect your treatment.

Do you have an existing illness: YES ☐ NO ☐ If yes please explain:

Have you ever had any of the following (please tick YES or NO)

Cardiovascular -	Heart Disease	YES ☐		NO ☐
	Heart Murmur	YES ☐		NO ☐
	Rheumatic Fever	YES ☐		NO ☐
	Open Heart Surgery	YES ☐		NO ☐
	Blood Pressure	HIGH ☐	NORMAL ☐	LOW ☐
	Stroke	YES ☐		NO ☐
Respiratory -	Asthma	YES ☐		NO ☐
	Chest & Lung Disease	YES ☐		NO ☐
	Sinus / Hayfever	YES ☐		NO ☐
Other -	Epilepsy	YES ☐		NO ☐
	Diabetes	YES ☐		NO ☐
	Kidney Problems	YES ☐		NO ☐
	Gastric Problems	YES ☐		NO ☐
	Radiotherapy	YES ☐		NO ☐

Do you smoke:		YES ☐	NO ☐
Are you taking any tablets, medicines, pills or drugs? If yes please list:		YES ☐	NO ☐
Have you ever had any allergies to medicines, or other substances (such as latex or foods) If yes 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 unfavorable reaction to an anaesthetic?		YES ☐	NO ☐
Are there any health matters you need to discuss with the dentist?		YES ☐	NO ☐
WOMEN: Are you pregnant? If so how many weeks?			
Are you currently suffering dental pain?		YES ☐	NO ☐
Do you currently have any issues with your teeth/tooth/gums or jaw? If yes please explain:		YES ☐	NO ☐
Are you happy with the appearance of your teeth?		YES ☐	NO ☐
When did you last visit the dentist?			
How did you hear about Remarkables Dental? Yellow Pages, Website, Friend/Family, Driving Past Surgery, Other:			

I agree to assume full financial responsibility for all dental treatment rendered. Payment is due on day of treatment (unless prior arrangement has been made) Accounts not paid within 30 days will be liable for collection costs.
A $25 fee may be charged for late cancelations less than 24 hours before the appointment or for a missed appointment.

I agree that the information I have given on this form is true and correct to the best of my knowledge.

Signature: Date:

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