Confidential Patient Questionnaire

This provides the Dentist with important information required for your Dental treatment and Oral Health Care.

Title ________ First name ______________________Surname__________________________

Home Address: ____

____ Post Code _______________________

Date of Birth: ____________________E-mail_______________________________________

Home Phone: ___________________________Mobile:___________________________

Occupation: ____

Details of person to contact in an emergency

Name: _______________________________ Phone Number__________________________

Medical History

Are you receiving any medical treatment at present time? Yes/No

Details: ____

Have you been a patient in hospital during the past two years? Yes/No

Details: ____

Have you taken any medicine tablets, capsules or drugs during the past two years? Yes/No

Details: ____

Any allergies or unusual effects from tablets, antibiotics, injections or anaesthetic? Yes/No

Details: ____

Are you or have you been under the care of a GP/Consultant during the past three years? Yes/No

Details: ____

Have you had any of the following? If so, please tick as appropriate:

Rheumatic fever	Heart trouble	High blood pressure	Asthma
Arthritis	Hepatitis A, B, C	Bronchitis/chest problems	
Headaches/migraines	Anaemia	Diabetes	Cold sore
Kidney trouble	Gastric problems	Depression	Drug use

Have you had any prosthetic surgery? (eg. Heart valve or hip replacement)________________________

Women, are you pregnant? Yes/No If so how many months:_____ Do you bleed excessively? Yes/No

Do you smoke? Yes/No How many? _____________ Weekly alcohol Intake ________________

Please be aware that our dental chairs have a maximum weight limit of135kg (21st). If you think you exceed this limit, please inform the dentist.

I consent to One Wood Street, Advanced Dental Care calling/leaving an answer phone message or message with a family member with the details of my dental appointment time and date. I am also aware that there is a late cancellation charge applied if I fail to give less than 2 days' notice to cancel my appointment.

Signature………………………………………….. Date……………..

No changes required Signature…………………………………………... Date…………….

No changes required Signature…………………………………………... Date…………….