

PATIENT QUESTIONNAIRE

Please complete all details

Please return to us **prior to the appointment** in the envelope provided.

It is essential to have a full and accurate medical history recorded into the patients' electronic file prior to their appointment.

Appointment Details:	Ortho No:								
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Family Name:	First Name:	Title:	
Preferred Name:	DOB:	/	/
Address:	Home Ph:	Patient Mobile:	
	Work Mother:	Work Father:	
	Mobile: Mother:	Mobile Father:	

If you would like a text reminder, Please advise the mobile number to send the reminder message to:

Email Address:	Is this routinely	Yes <input type="checkbox"/>	No <input type="checkbox"/>
School:	Or Occupation:		
Name of Family Dentist:	Approx Date of last Dental check up:	Name of Family Doctor:	
Who do you see for your dental treatment:	<i>Dentist Name:</i>	<i>School Dental Therapist:</i>	
Other family members who see us:	Who referred you?		

Full name(s) and address of person(s) responsible for account and pre-treatment fees:

Surname:	First Name:	Title:	
Surname:	First Name:	Title:	
Address:	Relationship to Patient:	Phone No:	
		ACC No if applicable:	

If You Are An Overseas Student:

Name of Guardian:	Phone:
Name and Address of Parents:	Phone:

PLEASE TURN FORM OVER FOR HEALTH QUESTIONNAIRE →

All of this information remains strictly confidential

Name:			
1.	Are you receiving any medical treatment at the present time?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.	Have you ever been in hospital for surgery/serious illness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.	Have you ever had any of the following?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Rheumatic Fever <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Drug Dependence <input type="checkbox"/>
	Heart Trouble <input type="checkbox"/>	Anaemia <input type="checkbox"/>	Depressive Illness <input type="checkbox"/>
	High Blood Pressure <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Cold Sores <input type="checkbox"/>
	Asthma <input type="checkbox"/>	Severe Headaches <input type="checkbox"/>	Gastric Trouble <input type="checkbox"/>
	Arthritis <input type="checkbox"/>	Bronchitis or Chest <input type="checkbox"/>	Kidney Trouble <input type="checkbox"/>
	Hepatitis – Specify A, B, C <input type="checkbox"/>		
4.	Are you taking any tablets, capsules, medicines or drugs of any sort?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes please list:			<input type="checkbox"/>
			<input type="checkbox"/>
5.	Have you had any allergies to medicines that you are aware of?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes please list:			<input type="checkbox"/>
			<input type="checkbox"/>
6.	Are you wearing an artificial or prosthetic joint?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7.	Have you ever experienced excessive bleeding or bruising?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8.	Have you had any accidents to your head, face or teeth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.	Have you ever come in contact with HIV or Hepatitis B virus?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10.	Have you ever had a reaction to an anaesthetic?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11.	Do you have any back or neck problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12.	Do you have a heart murmur that requires antibiotic cover for dental extractions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13.	Female, Are you currently pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Months:		
Are there any other aspects concerning your health that you think your Orthodontist should know about?			
Do you consent to the use of your treatment records for educational or communication purposes?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Agreement to pay for the consultation fee:			
I undertake to pay/or be responsible for ensuring the orthodontic consultation fee is paid at the time of the consultation appointment.			
If it is the intention that the consultation fee is to be covered by a third party, eg. ACC, Medical Insurance <u>I understand that I am liable for the full cost of the consultation fee at the time of the appointment</u> and will be reimbursed by the practice if the practice is paid by the third party at a later date.			
In the event of non-payment of the account, I will be liable for any recovery costs that may be incurred in obtaining payment of the account.			
I also understand and give consent for the treatment to be provided by registered Orthodontic Auxiliaries, or at times orthodontic auxiliaries in training for registration. I understand that all treatment will be under the direction of the orthodontist and that I have the right to ask that only registered oral health practitioners carry out this treatment.			
I/we confirm that the information contained is true and correct to the best of my/our knowledge:			
Signed: Patient / Parent / Guardian (Please circle)		Date:	
Please print your name:			
Comments or additional information:			
Medical History updated on:			