

## PATIENT QUESTIONNAIRE

Appointment Details:		Ortho No:							
Family Name:		First Name:		Title:					
Preferred Name:		DOB:		/		/			
Address:		Home Ph:		Father/Your Work Ph:					
		Work Mother:		Fax:					
		Mobile:		Other:					
Email Address:					Is this routinely used?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
School:		Or Occupation:							
Name of Family Dentist:		Approx Date of last Dental checkup:		Name of Family Doctor:					
Who do you see for your dental treatment	Dentist Name:		Or School Dental Therapist:						
Other family members who see us:	<i>(Important to complete this)</i>			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.  
Please return to us prior to the appointment in the envelope provided.*

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"/>	
	Heart Trouble <input type="checkbox"/>	Anaemia <input type="checkbox"/>	
	High Blood Pressure <input type="checkbox"/>	Diabetes <input type="checkbox"/>	
	Asthma <input type="checkbox"/>	Kidney Trouble <input type="checkbox"/>	
	Arthritis <input type="checkbox"/>	Gastric Trouble <input type="checkbox"/>	
	Hepatitis – Specify A, B, C <input type="checkbox"/>	Cold Sores <input type="checkbox"/>	
	Bronchitis or Chest Problems <input type="checkbox"/>	Depressive Illness <input type="checkbox"/>	
	Severe Headaches <input type="checkbox"/>	Drug Dependence <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:			
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:			
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"/>
<b>Agreement to pay:</b>			
I undertake to pay any charges that are incurred. If I have claimed to have the treatment covered by a third party, eg. ACC, Medical Insurance and the claim is not accepted, I understand that I am liable for the full cost of treatment or service received. I acknowledge that the Riccarton Orthodontic Practice does not accept responsibility for acquiring the fees from other third parties eg. other parent, relatives, family trusts etc. 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/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:			
<i>Office use only:</i>			
Medical History updated on:			