**Please fill in this questionnaire**

**Any information provided in the form will be treated with confidentially**

1. Title: Miss/Master/Ms /Mr/Mrs/Dr

2. Surname:…………………………………………………………..… Given name/s:……………………………………………………………..

3. Date of birth:…………………………… Home Ph No: …………………………………... Mobile:………………………………………..

4. Address:………………………………………………………………………………………………………………………………………………………

5. Email Address:………………………………………………..…………… 6.Occupation:……………………………………………………….

7. Health Fund name (if any):………………………………………………..…Number:…………………………………Series:…………..

8. Eligible for the Medicare Child Dental Benefits Scheme? Card no:…………………………….………..Series:…………..

9. Name of General Practitioner:………………………………….…………………..……… Ph No:………………………………………….

10. Have you ever suffered from any of the below conditions?

 □Heart condition/s □High/Low blood pressure □Arthritis/Rheumatic fever

 □Diabetes □Artificial joint/s □Excessive bleeding

□Stroke □Asthma/Sinus Problems □Hepatitis A/B/C/D

□Thyroid problems □HIV Infection □ Kidney problems

Others …………………………………………………………………………………………………………………………………………………………….
11. Are you taking any medications for osteoporosis ……………………………………………………………………………………..

12. Please list any medications, tablets, pills, or drugs you are presently taking………………………………………….....

………………………………………………………………………………………………………………………………………………………………………..

13. Do you suffer from allergies to any of the following?

□Penicillin □Latex □Local Anaesthesia □Sulpha group □Codeine □Aspirin □Others (specify):……………………………………………………………………………………………

14. Is there anything else about your health you believe we should know? (Please specify):…………………………..

 ……………………………………………………………………………………………………………………………………………………………………

15. Do you smoke? YES/NO

16. Are you pregnant or undergoing fertility treatment? YES/NO
17. Reasons for your visit today: ………………………………………………………………………………………………………………………
18. Please tick any dental concerns you have?

 □Toothache □Sensitive Teeth □Broken Teeth

□Cavities □Bad Breath □Bleeding Gums

□Dry Mouth □Discoloured Teeth □Missing Teeth

□Worn teeth □Grinding/Clenching Teeth

□Bad Appearance of teeth □Difficulty in opening the mouth

19. Have you ever had trouble/reaction associated with previous dental treatment? ......................................

……………………………………………………………………………………………………………………………………………………………………….

20. Do you feel apprehensive or nervous about dental treatment? YES/NO

21. Who is responsible for your fees:…………………………………………………………………..............................................

22. How did you find us:………………………………………………………………………………………………………………………………….

23. Signature:………………………………………………………………………………. 24. Date:………………………………………………….

**Thank you for taking your time to fill in this form. We hope it will help us provide you with the highest standards of treatment.**