

PURE BLISS DENTALCARE

Patients Dental and Medical Questionnaire

How did you find out about our clinic?

Walked by / Yellowpages / Local Newspaper / Flyers / Internet / Word of mouth /

Other _____

Mr. / Mrs. / Ms / Miss (Please circle)

First Name _____ Surname _____

D.O.B (dd/mm/yy) _____

Address: _____ Postcode: _____

Telephone numbers

Home _____ Work _____ Mobile _____

Email _____

Occupation _____

Health Fund _____ Member No. _____

Please indicate below which treatment/s interest you:

Treatment of pain only	
Regular check ups	
Regular hygiene for maintenance of healthy gums	
Cosmetic treatment	
Whitening of your teeth	
Implants (replacing of missing teeth)	
White fillings	
Other	

How would you prefer to be contacted by us? (please circle)

Recall Examinations	SMS	Phone call	Letter
Confirmation of Appointment	SMS	Phone call	

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Health Information

Date of Last Dental Visit _____ Reason for **this** visit _____

Have you ever had any of the following? Please check those that apply:

AIDS		Heart Disease		Tuberculosis	
Allergies		Heart Murmur		Tumors	
		Hepatitis		Ulcers	
		High Blood Pressure		Latex Allergy	
Anemia		Jaundice		Codeine Allergy	
Arthritis		Kidney Disease		Penicillin Allergy	
Artificial Joints		Liver Disease		Sulfa Allergy	
Asthma		Mental Disorders		OTHER:	
Blood Disease		Nervous Disorders		Pre Medication Needed	
Cancer		Pacemaker		Tobacco Use	
Diabetes		Currently Pregnant		Taking Coumadin	
Dizziness		Due date:		List any medications you are taking	
Epilepsy		Radiation Treatment			
Excessive Bleeding		Respiratory Problems			
Fainting		Rheumatic Fever			
Glaucoma		Rheumatism			
Growths		Sinus Problems			
Hay Fever		Stomach Problems			
Head Injuries		Stroke			

- Have you ever had any complications following dental treatment? Yes/No
If yes, please explain _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes/No
If yes, please explain _____
- Are you now under the care of a physician? Yes/No
If yes, please explain _____
- Name of Physician _____ Phone _____
- Do you have any health problems that need further clarification? Yes/No
If yes, please explain _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____

Date _____