AQUAINTANCE FORM AND CONFIDENTIAL HEALTH QUESTIONNAIRE

In order to provide dental treatment of a high standard, it is necessary to have the following information which will be handled confidentially.

Please fill in this form completely.

SURNAME:______________________ FIRST NAME: __________________ ____ PREFERRED NAME: __________________________

DATE OF BIRTH: ________________ ________________ MALE / FEMALE MR/MRS/MS/MISS/DR (Please Circle)

ADDRESS: ____ ____________________POSTCODE ____________

POSTAL ADDRESS (IF DIFFERENT) ____

OCCUPATION OR SCHOOL: ____

ARE YOU COVERED FOR DENTAL TREATMENT, IF SO WHICH FUND? ____

TELEPHONE NUMBERS – **PLEASE CIRCLE** PREFERRED DAYTIME CONTACT NUMBER

HOME: ___________________ WORK: ___________________ MOBILE: ________________EMAIL__________________________

I give permission to be contacted by SMS ☐ Yes ☐ No

FAMILY DOCTOR: ______________________________________ LOCATION ____

PLEASE TICK THE APPROPRIATE ANSWERS:

MEDICAL , AND DENTAL HISTORY	**YES**	**NO**
DO YOU HAVE A HEART MURMUR?		
DO YOU HAVE ANY OTHER EXISTING OR PRE – EXISTING HEART CONDITION? Please indicate problem		
DO YOU HAVE ANY BLEEDING PROBLEMS, OR OTHER BLOOD DISORDER?		
DO YOU HAVE AN ALLERGY TO ANY DRUG, MEDICINE, OR FOOD? PLEASE SPECIFY		
HAVE YOU EVER HAD RADIATION THERAPY TO YOUR HEAD, NECK,OR FACE FOR THE TREATMENT OF CANCER OR OTHER CONDITION?		
HAVE YOU TESTED POSITIVE FOR THE ANY OF THE FOLLOWING CONDITIONS? TUBERCULOSIS (TB) HEPATITIS B, OR C HIV/AIDS		

PLESE **CIRCLE** ANY OF THE FOLLOWING CONDITIONS THAT MAY BE RELEVANT TO YOU NOW OR IN THE PAST:

RHEUMATIC FEVER EPILEPSY ASTHMA DIABETES

HIGH OR LOW BLOOD PRESSURE CURRENTLY PREGNANT STROKE

LIVER DISEASE KIDNEY DISEASE HIP/KNEE OR OTHER JOINT REPLACMENT

PLEASE LIST **ALL** MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

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Additional Comments

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I give permission for my photograph to be taken as part of my records ☐ Yes ☐ No

SIGNED: ________________________________ DATE : _________________________