Health Questionnaire

Special Care Dental
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& Associates

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Dr / Mr / Mrs / Ms / Miss / Mast _____ Date: _____

Full name: _____
SURNAME GIVEN NAME

Address: _____

Postcode: _____

Phone: Home: _____ Work: _____ Mobile: _____

Date of Birth: / / Occupation: _____

Please direct my account to: _____

Health Insurance (name of fund): _____

Member No: _____ Member ID: _____

Medicare No: _____

Dept. Veterans Affairs No: _____ DVA Gold Card: Y/N

Pension No: _____

Whom may we thank for referring you to us? _____

Emergency Contact Details:
(Person to contact – other than the above address – in case of emergencies)

Name: _____ Phone: _____

Address: _____

Your Doctor: Name: _____ Phone: _____

Please circle the correct answer to all questions below.

Do you have, or have you ever had, any of the following conditions?

Y/N Heart trouble of any kind
Y/N High blood pressure
Y/N Rheumatic fever
Y/N Hepatitis A, B, C (Please circle)
Y/N Bleeding or blood disorders
Y/N Asthma
Y/N Diabetes Type 1 or 2 (Please circle)
Y/N Epilepsy
Y/N HIV (AIDS)
Y/N Women: Are you pregnant?
Y/N Have you been to hospital or had any medical treatment in the past 12 months?
Y/N Are you currently taking any medicines or tablets? (If yes, please specify)

_____

_____

Y/N Are you allergic to Penicillin?
Y/N Do you have any allergies? (If yes, please specify)

_____

_____

Any adverse reaction to previous dental treatment? (If yes, please specify)

_____

_____

_____

Any other illness?

_____

_____

_____

Is there any comment you wish to make in regard to your dental treatment?

_____

_____

_____

Please note that the dentist and staff have an ethical obligation to keep this information secret and guarantee confidentiality.

I agree to pay all costs related to recovery of overdue accounts, including debt collection, solicitor and legal fees. We may charge a cancellation fee if appointments are broken without 24 hours notice.

Signature: _____