Health Questionnaire

Special Care Dental

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& Associates

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Dr / Mr / Mrs / Ms / Miss / Mast

Full name:
SURNAME GIVEN NAME

Address:

Postcode:

Phone: Home: Work: Mobile:

Date of Birth: / / Occupation:

Email:

Person responsible for the account (if other than above) Name & address:

Health Insurance (name of fund):

Member No: Member Prefix No:

Medicare No: Pension No:

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

Whom may we thank for referring you to us?

Emergency Contact Details: (Person to contact in case of emergencies)

Name: Relationship: Phone:

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 (if yes please specify)

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 Are you allergic to Penicillin?

Y/N Are you or have you every been a smoker?

Y/N Have you been to hospital or had any medical treatment in the past 12 months? (if yes please specify)

Y/N Are you currently taking any medicines or tablets? **(If yes, please specify)**

Y/N Do you have any other allergies? (If yes, please specify)

Y/N Are you taking or have you ever taken biophosphonates? (medication for bone density ie Fosomax - if yes, please specify)

Any adverse reaction to previous dental treatment?

Any other illness?

Please note that the dentist and staff have an ethical obligation to keep this information confidential. I understand this information will be used to determine the dental treatment I receive and may be shared with other medical offices as necessary.

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: Date: