CONFIDENTIAL PATIENT QUESTIONNAIRE

THE CHILD DENTAL BENEFIT SCHEME DOES NOT APPLY TO NEW PATIENTS
This practice is not a preferred provider with any Health Fund.

If you have been sick or unwell recently, please tell us immediately

PATIENT: Surname:_____ First Name:_____ M/F/NB:_____

Date of Birth: _____

Details of Parent/Carer to contact for appointments / Payments / in case of emergency:

Carer 1: Mrs/Ms/Mr/Dr Name: _____ Relationship to patient _____

Carer 2: Mrs/Ms/Mr/Dr Name: _____ Relationship to patient _____

Phone Number: Carer 1 _____ Carer 2 _____

Email: Carer 1_____ Carer 2_____

Address: _____ Post code_____

Private Hospital Cover Yes/No, Dental Cover: Yes/No

Do you have other children that have attended this practice? Yes / No **Name:**_____

MEDICAL HISTORY: (Please answer for your child)

1. Is your child receiving any medical treatment at the present time? Yes / No
   Details: _____
2. Has your child been a patient in hospital, including any operations? Yes / No
   Reason: _____
3. Is your child taking any medications now or during the past two years? Yes / No
   Details: _____
4. Has your child experienced any allergies to medications or anaesthetic? Yes / No
   Details _____

5. Has your child had any of the following? If so, please tick as appropriate.

	Rheumatic Fever		Epilepsy		Severe Headaches
	Heart Trouble		Anaemia		Cancer
	Allergies or anaphylaxis		Diabetes		Anxiety disorders
	Asthma		Kidney Trouble		Bronchitis or Chest Problems
	Bleeding disorders		Gastric Problems		Autism spectrum disorders
	Infectious diseases		Other (please specify)		

6. Does your child snore or have a history of sleep apnoea? Yes/No
   Details: _____

DENTAL HISTORY:

1. Name of referring practitioner (if applicable) _____
2. Approximate date of last dental visit:
   Details: _____
3. Does your child have any Dental pain or a Dental problem at present? Yes / No
   Details: _____
4. Has your child ever experienced excessive bleeding or bruising from dental treatment? Yes / No
5. Does the patient become overly anxious or uncomfortable when he/she is having dental treatment? Yes / No

It is the policy of this practice that all accounts are to be paid on the day of treatment. Payment by cash, credit card or EFTPOS. We do not accept cheques.

Signed (parent/guardian)…….. Date: ____/____/_____