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

Details: 2. Has your child been a patient in hospital, including any operations? Reason: 3. Is your child taking any medications now or during the past two years? Details: 4. Has your child experienced any allergies to medications or anaesthetic? Petails 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 Proble Bleeding disorders Gastric Problems Autism spectrum disorder Infectious diseases Other (please specify) 6. Does your child snore or have a history of sleep apnoea? Petails: ENTAL HISTORY: Name of referring practitioner (if applicable) Approximate date of last dental visit: Details: Does your child have any Dental pain or a Dental problem at present? Yeo Details: Has your child ever experienced excessive bleeding or bruising from dental treatment?	Relationship to patient Relationship to patient Carer 2 Post code	ATIENT:	Surname:	First Name:	M/	F/NB:
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