MILFORD DENTISTS

info@milforddentists.co.nz phone 09 489 6575
170 Kitchener Rd, Milford

Family Name: ______________ First Name: ______________
Date of Birth: ______________ Occupation: ______________
Address: ______________
Telephone Numbers: Home: ( ) __________ Work: ( ) __________ Mobile: __________
E-mail address (we can e-mail appointment reminders): ______________
What is the best way for us to contact you? Please underline: Home ph Work ph Mobile E-mail Post SMS
Name of your GP: ______________
If under 20 - Name & address of parent/guardian: ______________

CONFIDENTIAL HEALTH QUESTIONNAIRE

In order to provide the best & safest dental treatment & oral health care, we need to know of any medical problems which may affect your treatment.

1. Are you receiving any medical treatment at the present time? Yes/No
   If yes for what: ______________
2. Have you ever been in hospital recently, or for anything serious? Yes/No
   If Yes for what: ______________
3. Have you ever had any of the following? (please tick box)

Rheumatic Fever ☐	Epilepsy ☐
Heart Trouble ☐	Anemia ☐
High Blood Pressure ☐	Diabetes ☐
Asthma ☐	Kidney Trouble ☐
Arthritis ☐	Gastric Problems ☐
Hepatitis - A.B.C ☐	Cold Sores ☐
Bronchitis or Chest Problems ☐	Depressive Illnesses ☐
Severe Headaches ☐	Drug Dependence ☐
Bleeding Problems ☐	

4. Are you taking any tablets, capsules, medicines or drugs? Yes / No
   If yes please list: ______________
5. Have you any allergies to medicines that you are aware of? Yes / No
   If yes please list: ______________
6. Do you have a prosthetic or artificial joint or heart valve? Yes / No
   If yes when was this placed ______________
7. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? Yes / No
8. Have you ever had any contact with the AIDS virus or Hepatitis B virus? Yes / No
9. Have you ever had a reaction to an anaesthetic? Yes / No
10. Women: Are you pregnant now? Yes / No Months Due Date: / /
11. Are there any other aspects concerning your health that you think we should know about?

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Reason for attending today: ______________
Date of last dental visit: __________ Last dental cleaning: __________ Last full mouth X-Rays: __________
How often do you have dental examinations? ______________
How often do you brush your teeth? __________ How often do you floss? __________
What other aids do you use (Interdental brushes, toothpicks, etc.)?

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HAVE YOU EVER HAD:

Orthodontic Treatment	Yes / No
Oral Surgery	Yes / No
Specialist gum treatment	Yes / No
A grinding Splint	Yes / No
A serious injury to the mouth or head	Yes / No

DO YOU:

Clench or grind your teeth regularly	Yes / No
Have tired jaws, especially in the morning	Yes / No
Smoke/chew tobacco	Yes / No

ARE ANY OF YOUR TEETH SENSITIVE TO?

Hot or cold	Yes / No
Sweet	Yes / No
Biting or chewing	Yes / No

HAVE YOU NOTICED:

Any mouth odours or bad taste	Yes / No
Your gums bleeding	Yes / No

HAVE YOU EXPERIENCED:

Clicking or popping in the jaw	Yes / No
Difficulty in opening or closing the mouth	Yes / No
Difficulty chewing on either side of the mouth	Yes / No

Are there any areas where food gets trapped after meals? Yes / No
Do you feel nervous about having dental treatment? Yes / No
If so what is your biggest concern? ______________
How did you hear about us? Please indicate e.g. Yellow pages (book), online yellow, signage, website, search engine, referral from family or friend (please name), other: ______________
Is another member of your family a patient at our office? Yes / No
Name: ______________ Relationship: ______________
Person to contact In Case of Emergency: ______________ Phone: ______________
Is there anything else about having dental treatment that you would like us to know? :

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Signed by: Patient/Parent/Guardian: ______________ Date: / /

Please let us know if you are unable to attend to give us time to book someone else into your time slot. For appointments under 1 hour long a charge of $25 per 15 minutes will be made for cancellations made under 24 hours prior to your appointment time or failed appointments. For appointments longer than 1 hour a charge of $25 per 15 minutes will be made for cancellations made under 48 hours prior to your appointment time or failed appointments.
We are always happy to provide you with written or verbal estimates on request, for all, or part of your proposed treatment plan.
In accepting services at Milford Dentists Ltd, a word about our credit terms – Please note accounts are payable after each appointment.
If an account is not paid within 30 days after the due date, our debt recovery agency may charge you a fee equal to 25% of the unpaid portion of the price & other legal & recovery costs not covered by the fee, but not less than $25. The account may also be recorded on the credit information database held by Baycorp Business Information Services. Interest at 2% monthly and bank costs, will be charged on any overdue payments and uncleared cheques.

Data entry checked by: ☐

Exact:Medical History/Contacts/Medical History