MILFORD DENTISTS

info@ pearlywhites.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 phone Work phone Mobile E-mail Post

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 anesthetic? 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?

_____

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.)?

_____

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 you satisfied with your teeth's appearance? ..... Yes / No
Would you like to keep your teeth all of your life? ..... 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? :

_____

_____

_____

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

In accepting services from Milford Dentists Ltd today and in the future - a word about our credit terms. Accounts are payable after each appointment. Interest at 2% monthly, an administrative fee of $35 and bank costs, will be charged on any overdue payments and uncleared cheques from the date of treatment. Please let us know if you are unable to attend your appointment by giving us 24 hours' notice. A charge of $25 per 15 minutes will be made for same day cancellations (up to 24 hours prior to your appointment) or failed appointments. We are always happy to provide you with written or verbal estimates on request, for all, or part of your treatment plan. If an account remains unpaid within 30 days of due date, our debt recovery agency may charge you a fee equal to 25% of the unpaid portion of the treatment costs & 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.

Data entry checked by: _____