Herald Avenue
DENTAL CENTRE

CONFIDENTIAL PATIENT QUESTIONNAIRE

Name: ____
Surname First Names Dr / Mr / Mrs / Miss / Ms

Preferred Name: ______________________ Health Fund: ______________________

Home Address: ______________________ Home Phone: ______________________

City/Suburb: ______________________ Mobile Phone: ______________________

Post Code: ______________________ Occupation: ______________________

Date of Birth: ______________________ Email Address: ______________________

Next of Kin/Emergency Contact Details:

Name: ____________________ Phone Number: ________________Relationship:__________________

Are you happy with your smile? Yes/No
If no, what don't you like about it? ____

Would you like to receive promotional offers from Herald Avenue Dental? Y/N

MEDICAL HISTORY

1. Are you receiving any medical treatment at the present time? Yes/No

   If so, please provide details; ____

2. Have you experienced any allergies or adverse effects from any medication, materials and anaesthetic? Yes / No

   If so, please provide details; ____

3. Does any of the following apply to you? If so, please tick as appropriate;

   ☐ Rheumatic Fever
   ☐ Heart Trouble
   ☐ High Blood Pressure
   ☐ Asthma
   ☐ Chemotherapy or Radiotherapy
   ☐ Epilepsy
   ☐ Prosthetic joint
   ☐ Diabetes (Type 1 or 2)
   ☐ Liver or Kidney Disease
   ☐ Smoker
   ☐ Hepatitis B or C
   ☐ HIV/AIDS

   Details: ____

4. Are you taking any medications? If yes please specify:

   ____

   ____

5. Are you pregnant? Yes/No If so, how many months: ____________________

DENTAL HISTORY

1. When was your last visit to see a dentist? ____
2. Are you experiencing any dental pain/problems at present? ____

Preferred contact Method? (Please circle) Text Message / Phone Call / Email

How did you hear about us?

☐ Doctors Surgery
☐ Street Sign
☐ Flyer
☐ Health Engine
☐ Google search
☐ Local Sports club
☐ Facebook
☐ Another patient/friend (Name) ____________________

Signed: Patient/Parent/Guardian ______________________________ Date: ______________