

**COOK, DILLON AND BRUDENELL
HEALTH QUESTIONNAIRE**

Patient Details

Name: (Mr/Mrs/Miss/Ms).....
(first names) (family name)

Preferred First Name:..... Date Of Birth: Current Age:.....

Address:.....

Phone: (home).....(work).....(mobile).....(e-mail).....

School/Employer:..... Occupation:.....

Name of Referring Dentist: Family Dentist:.....

Who Referred/Told you about our practice:.....

Have any other family members been seen in this practice:

Payee Details

Person/s Responsible for Payment: (1).....
(first names) (family name)

(2).....
(first names) (family name)

Relationship to Patient:.....

Address to where accounts should be sent:.....

Contact Phone No's: (1) (home).....(work).....(mobile).....

(2) (home).....(work).....(mobile).....

Which Health Fund, if any, do you belong to?..... Do you have Dental cover?.....

Medical History

To ensure our treatment is compatible with your present state of health, please answer the following questions:

Are you at present receiving medical treatment?..... If yes, for what condition?.....

Please list any medicines or tablets you are taking.....

Are you allergic to any drugs or medicines?..... If yes, name the drug you are allergic to:.....

Do you have any other allergies?..... Name of your Medical Practitioner:.....

Have you had your adenoids or tonsils removed?..... If yes, when?.....

What serious illnesses have you had? (Especially any heart problems; rheumatic fever; diabetes; liver, kidney or thyroid diseases; epilepsy; asthma; hepatitis; any other blood disorders)
.....

Are you pregnant?..... If yes, what is your due date?.....

Do you suffer from Excessive fear of dental treatment?.....

In signing this form I acknowledge that this represents an accurate medical history and is a request for express consent. Use of the information contained hereon will be used only for the primary purpose for which it is collected. I will also supply my dentist with any relevant changes to this history as required. All medical information will be treated with complete professional confidentiality within the guidelines of the Privacy Act 12/01 and through the obligations health service providers have under the professional and ethical codes of practice.

In the event that our accounts are not paid within our normal trading terms (30 days from the date of the invoice) I/We agree to pay all reasonable debt collection costs and commissions to recover any overdue money.

Signed:..... Date:.....
(Parent/Guardian if under 18 years of age)