Hamilton Orthodontics **Specialist Orthodontic Practice**

the smile SPECIALISTS

Confidential Patient Questionnaire

Patient details

First name | Middle name | Surname

Date of birth | ◯ Male ◯ Female (Please tick one) | School name or Occupation | Phone

Postal address | Mobile

Email

Post Code

How did you hear about us? Dentist, school, friend, website, advert, google, cleft clinic

When did you last visit a dentist?

Are you taking any tablets, medicines, pills or drugs? If yes, please list:

Name of your family dentist

Have you ever had an allergic reaction to medicines, or other substances such as latex? If yes, please list:

Have you ever had any of the following?

- ◯ Heart murmur
- ◯ Rheumatic fever
- ◯ Open heart surgery
- ◯ High blood pressure
- ◯ Stroke
- ◯ Other (Please provide details)
- ◯ Asthma
- ◯ Chest and lung disease
- ◯ Sinus/Hay fever
- ◯ Epilepsy
- ◯ Diabetes
- ◯ Kidney problems
- ◯ Gastric problems
- ◯ Depressive illness
- ◯ Radiotherapy
- ◯ None of the above

Have you ever had contact with:

- ◯ HIV virus
- ◯ Hepatitis B virus
- ◯ Hepatitis C virus

Yes/No

- ◯ ◯ Do you have an artificial or prosthetic joint?
- ◯ ◯ Have you ever experienced excessive bleeding or bruising from dental treatment, or at any other time?
- ◯ ◯ Have you ever had an allergic reaction to an anesthetic?
- ◯ ◯ Women: Are you pregnant? If so, how many weeks? _____
- ◯ ◯ Do you smoke?

Account holder details (must be over 18 years)

Mr/Mrs/Miss/Ms/Dr/Prof | First name | Surname

Relationship to patient | Phone

Address (If different to above) | Mobile

Email

Please sign below

Signed by patient | Date

Signed by parent/guardian | Date