Personal and Health Questionnaire

Name_____

Address_____

_____

Home phone_____ Mobile_____

Birth date_____ Email_____

Names of other family members attending the practice_____

Person financially responsible _____

Address_____

_____

Dentist_____

Health Insurance provider_____

To ensure that our treatment is compatible with the patient's state of health please answer the following:

Are you currently receiving medical treatment? No ☐ Yes ☐ (and provide details below)

Doctor_____ Phone or address_____

Current medications:_____

_____

Have you suffered from any of the following? Please tick if yes

Rheumatic fever	☐	Heart complaints	☐	Tonsils/Adenoids	☐
Asthma	☐	Diabetes	☐	Hepatitis	☐
Epilepsy	☐	Jaundice	☐		

Please tick if you are: pregnant ☐ a smoker ☐ high risk for HIV ☐

Please list any allergies or adverse reactions to medication or other substances _____

_____

Please list any medical conditions or concerns not already covered above_____

_____

Please tick	
☐	I authorise Greater Springfield Orthodontics to forward my clinical records to a doctor or dentist as an aid to diagnosis or treatment
☐	I consent to photographs being used for teaching and/or training

Signed by: _____ Signature: _____Date: _____