Welcome to
Saltford Dental Practice
478 Bath Road,
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CONFIDENTIAL PATIENT QUESTIONNAIRE

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This form provides your Dentist with important information required for your dental treatment and oral health care.

Please write in black ink, block capitals and circle the correct answer

CHILD PATIENTS AGED UNDER 16 YEARS

First names:……..

Surname:……

Date of Birth:……./……./…….

Home address:……
……
……
Postcode:……

Home phone:……

Parent/Guardian Mobile phone:……

Parent/Guardian Email address:……..

Details of person to contact in an emergency:

Name:…… Phone number:……

Doctors name:……..Address:……
……Postcode:……
Phone number:……

Medical History

1. Is your child receiving any **medical** treatment at the present time?
Yes/No……
2. Has your child been a patient in **hospital** during the past two years?
Yes/No……

Please turn over…….

3. Has your child taken any **medicine, tablets, capsules** or **drugs** during the past two years? **Please note/provide up to date medication list and dose**
   Yes/No……
4. Has your child ever, or do you currently take any **steroid** based medication? If so please provide details Yes/No……
5. Has your child ever experienced any **allergies** or unusual effects from any tablets, drugs, injections or anaesthetics? Yes/No……
6. Is your child, or has your child been under the care of a **doctor** during the past two years?Yes/No……
7. Have you ever had any of the following?

   If so please tick as appropriate.

Rheumatic Fever	☐	Epilepsy	☐	Asthma	☐
High Blood Pressure	☐	Diabetes	☐	Arthritis	☐
Gastric Problems	☐	Cold sores	☐	Drug Dependence	☐
Bronchitis/Chest Problems	☐	Depressive Illness	☐	Kidney Trouble	☐
Severe Headaches	☐	Hepatitis A/B/C	☐	Heart Trouble	☐
Anaemia	☐				

Dental History

1. Name and address of last Dentist?……
2. Approximate date of last visit?……
3. Does your child have dental pain or a dental problem at present?
   Yes/No Details:……
4. Has your child ever experienced excessive **bleeding** or **bruising** from dental treatment, cuts or scratches? Yes/No
5. Does your child become **anxious** or **uncomfortable** when you are having dental treatment? Yes/No
6. How often does your child **brush** his/her teeth? ……

Please could you tell us how you found out about registering as a new patient at our practice? *Please tick one of the following*

Leaflet delivery ☐ Word of mouth/recommendation ☐ Internet ☐ Advert ☐ Other ☐

Signed: Patient/parent/guardian…… Date:……/……/……

Scrutinised by dentist:…… Date:……/…../……

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dental practice