R. J. BEGG & ASSOCIATES LTD

PATIENT QUESTIONAIRE

NAME: _____ MR / MRS / MISS / MS
(Surname) (First Names)

ADDRESS: _____

_____Post Code _____ Occupation: _____

Telephone (hm): _____ Date of Birth: _____

(wk): _____ (Mobile): _____

Email: _____

Person who referred you: _____

Next of Kin: Name: _____

Address: _____

Mobile/ Contact Phone _____ Relationship to patient: _____

Name and Address of person responsible for account –(if not patient).

_____

If you have Medical Insurance please name the Company: _____

Name of Dentist: _____

Name of Medical Practitioner: _____

Address of Medical Practitioner : _____

Please answer these questions if your visit to us is ACC related
Date of accident relating to this injury: _____

ACC Claim number: _____
Payment Note:

If I have claimed to have my treatment covered by a third party, eg. ACC and the claim is not accepted within three months I understand that I am liable for the full cost of treatment received. In the event of non-payment of my account I will be liable for any recovery costs, legal fees and commissions that may be incurred in obtaining payment of my account.

1. Are you receiving any medical treatment at the present time? YES / NO

2. Have you ever been in hospital? YES / NO

3. Have you ever had any of the following? (Please tick ✓)

Rheumatic Fever		Epilepsy	
Heart Trouble		Anaemia	
High Blood Pressure		Diabetes	
Asthma		Kidney Trouble	
Arthritis		Gastric Problems	
Hepatitis Specify type A,B or C		Cold Sores	
Bronchitis or Chest Problems		Depressive Illness	
Severe Headaches		Drug Dependence	

4. Are you taking any tablets, capsules, medicines or drugs? YES / NO

5. Have you any allergies to medicines that you are aware of? YES / NO

6. Are you wearing an artificial or prosthetic joint? YES / NO

7. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? YES / NO

8. Have you ever had contact with the AIDS virus or Hepatitis B virus YES / NO

9. Have you ever had a reaction to an anaesthetic? YES / NO

10. (Women) Are you pregnant at the moment? YES / NO

11. If you are pregnant - how many months pregnant are you? …….

Are there any other aspects concerning your health that you think we should know about?

_____

_____

Do you consent to the use of your treatment records for educational or communication purposes YES / NO

To my knowledge the above is a true and accurate account of my medical history and personal details.

Agreement to pay

I undertake to pay any charges that I incur. If I have claimed to have my treatment covered by a third party, eg. ACC or medical Insurance and the claim is not accepted within three months I understand that I am liable for the full cost of treatment received. In the event of non-payment of my account I will be liable for any recovery costs, legal fees and commissions that may be incurred in obtaining payment of my account.

Signed: _____ Date: _____

Surgeon to complete next section at appointment time

REQUEST FOR SURGERY / PROCEDURE

I, ……agree that I have received a reasonable explanation of the intent, risks and likely outcomes of the treatment and operation of …… and an explanation of the alternative procedures which may be necessary in relation to my current treatment, and to the administration of General Anaesthetic / Local Anaesthetic / I.V (Intravenous) Sedation. I understand and am satisfied that I may seek more information and participate in decision making. I accept the advice of ……..… regarding this operation, treatment and care to be carried out.

Surgeon's Signature: ..... Date: .....

Patient's Signature: ..... Date: .....

If not patient state your relationship to patient: .....