NSEndo
North Shore Endodontics Ltd
Richard Ellis BDS, CertEndo
Diplomate, American Board of Endodontics
Ray Sun BDS, DClinDent

Patient Registration and Health Questionnaire

Please answer all the questions as accurately as possible. The information will be retained as part of your confidential patient record.

First name: _____ Last name: _____

Title: Mr / Mrs / Miss / Ms

Date of Birth: _____

Referring Dentist: _____ Family doctor: _____

Address: _____

Email: _____

Mobile: _____ Home phone: _____

Next of kin

Name: _____

Relationship: _____

Mobile: _____ Home phone: _____

Please answer **Yes** or **No** if you suffer from, or have you ever suffered from the following:

High blood Pressure	□ Yes □ No	Shortness of breath	□ Yes □ No	Blackouts/fainting	□ Yes □ No
Previous heart attack	□ Yes □ No	Sleep Apnoea	□ Yes □ No	Epilepsy	□ Yes □ No
Heart murmur	□ Yes □ No	Anaemia	□ Yes □ No	Recreational Drugs	□ Yes □ No
Palpitations	□ Yes □ No	Excessive bleeding	□ Yes □ No	Steroids	□ Yes □ No
Artificial heart valve	□ Yes □ No	Blood clots	□ Yes □ No	Joint or metal Implant	□ Yes □ No
Chest pains/angina	□ Yes □ No	Blood transfusion	□ Yes □ No	Arthritis	□ Yes □ No
Previous rheumatic fever	□ Yes □ No	Hepatitis/Jaundice	□ Yes □ No	Stroke	□ Yes □ No
HIV+/AIDS	□ Yes □ No	Do you smoke	□ Yes □ No	Do you drink alcohol	□ Yes □ No
Asthma	□ Yes □ No	Kidney problems	□ Yes □ No	Diabetes	□ Yes □ No
Tuberculosis	□ Yes □ No	Bronchitis	□ Yes □ No	Hiatus Hernia	□ Yes □ No

Have you ever taken medication for Osteoporosis e.g. Fosamax?	□ Yes □ No
Have you ever had radiotherapy to the head or neck?	□ Yes □ No
Women Only: Are you or could you be pregnant? If yes, how many weeks: _____	□ Yes □ No

Turn to page 2

Please provide details if you have answered "yes" to any of the above:

Are there any major illnesses, to your knowledge, among your blood relatives? □Yes □ No
e.g. Diabetes, Heart conditions:

Relationship: _____ Illness: _____

Relationship: _____ Illness: _____

List all previous admissions to hospital:

Reason for admission	Hospital	Approximate date

List ALL current medication: (including natural remedies) or bring a list with you.

Drug name	Dose	Time of day taken

List any allergies to medication, tablets, plasters, food, LATEX. or any other substances

Substance	Type of reaction

The details above have been completed by patient / guardian / relative / other **(please circle).**

I agree to receive special consultation including x-rays. I acknowledge full responsibility for the payment of such services and agree to pay after each treatment unless other specific arrangements are made with the reception.

I am aware that overdue and unpaid accounts will be sent to a debt collection agency which may have implications on my credit rating. I accept full responsibility for all debt collection to recover overdue accounts in my name.

If signing on behalf of a minor (under 18 yrs), I accept full responsibility for all treatment costs accrued on their behalf.

Name: _____ Signed: _____ Date: _____