Medical questionnaire

Family doctor name:

_____

Please circle your answer to the following questions

Are you presently receiving any medical treatment? Yes | No

Have you any allergies that you are aware of? Yes | No

Have you ever experienced excessive bleeding from dental treatment, cuts or scratches? Yes | No

Any change in your general health in the past year? Yes | No

Please tick the box if your answer is yes

Have you ever had any of the following?

- ☐ Rheumatic fever
- ☐ High blood pressure
- ☐ Arthritis
- ☐ Bronchitis
- ☐ Severe headaches
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Gastric problems
- ☐ Depressive illness
- ☐ Tuberculosis (TB)
- ☐ Heart trouble
- ☐ Asthma
- ☐ Hepatitis
- ☐ Chest pains
- ☐ Thyroid problem
- ☐ Anaemia
- ☐ Kidney trouble
- ☐ Cold sores
- ☐ Drug dependence

Please provide details:

_____

_____

_____

Have you ever taken long term medication? Yes | No

(If yes, please name)

_____

Have you any allergies to medicines that you are aware of? Yes | No

(If yes, please name)

_____

Are you wearing an artificial joint eg. hip joint? Yes | No

Have you ever had contact with the AIDS virus or Hepatitis B virus? Yes | No

Have you ever had a reaction to an anaesthetic? Yes | No

Are you pregnant now?
(If yes, pregancy due date) _____ Yes | No

Are there any other aspects concerning your health that you think we should know about? Yes | No

(If yes, please indicate)

_____

Are you currently taking any drugs or medicines? Yes | No

Does your jaw 'click' or hurt? Yes | No

Do you feel you grind your teeth? Yes | No

Have you ever had orthodontic treatment? Yes | No

Do you think you have occasional bad breath? Yes | No

Do your gums ever bleed when you clean your teeth? Yes | No

Additional information:

_____

_____

_____

please continue on other side ▸

School Smiles Programme enrolment form

*FREE treatment for year 9-13**

If you require more than one enrolment form, please contact us. Visit our website to download a form.

First Name(s): _____

Surname: _____

Date of Birth: _____

Gender Male | Female

Parent/Guardian Name: _____

Residential Address: _____

Secondary School:

_____

Nationality - in which country were you born?

_____

Contact Phone Number:

(day): _____ (night): _____

(mobile): _____

Email: _____

Consent to Enrolment

I/We agree

- this information is true and correct
- to enrol with Lumino the Dentists for an oral health examination and treatment.*
- Lumino may transfer my records from my previous dental provider.
- that my personal details and treatment information to be sent to the Local District Health Board and the Ministry of Health for provider payment and clinical data collection purposes.
- the enrolled child has not visited another clinician in the last 12 months.

Signed: _____

Date: _____

Parent or legal guardian must sign this form if the enrolling patient is under 16 years.

Please tear off the completed enrolment form and post back to us: Lumino The Dentists, PO Box 106514, Auckland 1143 or drop it off at the school reception.

*Once enrolled, your child will be entitled to free treatment until they turn 18 years of age. There is no need to re-enrol every year. Your child will remain enrolled with Lumino The Dentists, unless you request their removal. Please contact us on 09 361 7198 or schoolsmiles@lumino.co.nz if there has been any change in your child's medical history, you have moved house, your child has changed schools or you would like your child to be removed from our records.

This service is available only to students who are NZ residents.