dentistryillawarra

PERSONAL DETAILS

Surname		**Name**
○ Mr ○ Mrs ○ Ms ○ Miss ○ Dr Other	Preferred Name	Date of Birth dd / mm / yyyy
Address		
Suburb		Post Code
Home Phone	Mobile	Work
Email		Occupation
IN CASE OF EMERGENCY		
Contact Name	Relationship	Phone
MEDICAL DETAILS		
Medicare No	Position on Card	Expiry Date
GP Name	Location	Phone
Vet Affairs ○ Gold ○ White	Card No.	Expiry Date
Private Health Fund ○ Yes ○ No	Name	Member ID
CONTACT SYSTEM		
Would you like us to remind you of your next appointment?	○ **Yes** (please specify below) ☐ Call home ☐ Call mobile ☐ Call work ☐ SMS ☐ Email	○ **No**
Please select your preferred contact system for your active maintenance (ie. every 6, 9 or 12 months)	☐ Call home ☐ Call mobile ☐ Call work ☐ SMS ☐ Email ☐ Letter Other:	
How did you hear about us?	**Referred by:** ○ Other patient please name ○ Friend/ Family please name ○ GP please name ○ Health Fund please name ○ Staff please name ○ Internet ○ Newspaper ○ Other please name	

DENTAL HISTORY

Why have you come today?

How long is it since your last dental examination?

○ 6 months ○ 1 year ○ 2 years ○ 3 years ○ Longer

Your current dental health is:

○ Good ○ Fair ○ Poor

How many times do you brush your teeth?

○ 1 x Daily ○ 2 x Daily ○ 3 x Daily

Do you floss?

○ Daily ○ Occasionally ○ Rarely ○ Never

Please select any dental concerns you may have:

☐ Toothache ☐ Missing teeth ☐ Pain in face or jaw joints
☐ Sensitive teeth ☐ Unsatisfactory denture ☐ Sounds from joint
☐ Bleeding gums ☐ Decaying teeth ☐ Difficulty chewing
☐ Loose teeth ☐ Lost filing / cavity ☐ Discoloured teeth
☐ Bad breath ☐ Grinding / clenching teeth ☐ Bad appearance of teeth
☐ Dry mouth ☐ Worn / broken teeth ☐ Other:

Do you feel nervous about your treatment?

○ **Yes** ○ **No**

Comments:

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MEDICAL HISTORY

Have you ever had or are you suffering from any of these?

- ☐ Heart disease / Surgery
- ☐ Cardiac pacemaker
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Diabetes
- ☐ Hepatitis ○ A ○ B ○ C
- ☐ Arthritis
- ☐ Thyroid trouble
- ☐ Epilepsy
- ☐ Sleep apnoea
- ☐ Stroke
- ☐ Stomach or digestive condition / reflux
- ☐ Osteoporosis
- ☐ Rheumatic fever
- ☐ Nervous disorders
- ☐ Asthma
- ☐ HIV / AIDS
- ☐ Liver or kidney disease
- ☐ Excessive or prolonged bleeding
- ☐ Radiation or chemotherapy
- ☐ Eating disorder
- ☐ Prosthetic implant / joint replacement
- ☐ Organ or bone marrow transplant
- ☐ Steroid therapy
- ☐ Cancer
- ☐ Other (please specify):

Do you currently smoke?

○ **No** ○ **Yes** - Since year ○ **Stopped** year

Are you taking any medications, drugs or natural remedies now?	○ **Yes** (please list) ○ **No**
Are you taking any Biphosphonate Medications? (commonly used for Osteoporosis and bone disease treatment)	○ **Yes** (please select) ○ **No** ☐ Alendronate ☐ Risedronate ☐ Actonel ☐ Pamisol ☐ Adronat ☐ Fosamax ☐ Disodium Pamidronate ☐ Zoledronate ☐ Aclasta
Do you have any allergies? i.e. antibiotics, latex, local anaesthetic, codeine.	○ **Yes** (please list) ○ **No**

FOR WOMEN

Are you pregnant?

○ **No** ○ **Unsure** ○ **Yes** - Week No:

Are you breast-feeding?

○ **No** ○ **Yes**

I have accurately completed this pre-clinical questionnaire to the best of my knowledge . It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentist and their staff and I assume full financial responsibility for said treatment.

Print Form

Email Form

Patient Signature _____ **Date** dd / mm / yyyy

(Parent or Guardian to sign if patient is a minor)

All forms need to be signed in person at Dentistry Illawarra

Please Note:
If you are sending a filled-in form via email using Internet Email (ie: Yahoo, Hotmail, Gmail). Please save PDF form to Desktop and attach to email.