Dentistry FOR you

Welcome to Dentistry for You

To help us give you the best possible treatment, please answer the following confidential questions to help us get to know better and understand your dental needs.

Title: Dr / Mr / Mrs / Ms / Miss / Master (*please circle*)
Surname: _____
First Name: _____
Address: _____
Suburb: _____Post code: _____
Emergency contact: _____

Date of Birth: ___/___/____
Phone: _____
Mobile: _____
Email: _____
Occupation: _____
Emergency contact number: _____

Are you covered for **Dental** by a health fund? ❑ Yes, fund name: _____ ❑ No
Fund card number: _____ID:____
Are you currently receiving medical treatment? ❑ Yes, details: _____ ❑ No
_____
Are you taking any **medications**: ❑ Yes, please list overleaf ❑ No
Have you ever suffered a serious illness? ❑ Yes, details: _____ ❑ No
_____
Do you have **any** allergies? *(foods/medicines/latex)* ❑ Yes, details: _____ ❑ No
_____
Have you had any dental treatment in the past that you would like us to know about? ❑ Yes, details: _____ ❑ No
_____
Do you have any abnormal reactions to local or general anaesthesia? ❑ Yes, details: _____ ❑ No
_____
Do you **smoke**? ❑ Yes, how many per day? _____ ❑ No
Have you taken **aspirin** in the past two days? ❑ Yes ❑ No
Have you taken **steroids** in the past two days? ❑ Yes ❑ No
Are you on any medications/injections for bone weakness? (**osteoporosis**) ❑ Yes ❑ No
Are you pregnant or breastfeeding? (females only) ❑ Yes ❑ No
Do you normally require **antibiotic cover** before dental treatment? ❑ Yes ❑ No
Are you Indigenous or Torres Strait Islander? ❑ Yes ❑ No

Please tick if you have or have had any of the following:

☐ Heart attack, disease, surgery, murmur, disorder or complaint	☐ Respiratory disease	☐ Stroke	☐ Asthma
	☐ Bruise/bleed excessively	☐ Bone disease	☐ Hepatitis (A / B / C)
	☐ Artificial joints	☐ Blood disease	☐ HIV or AIDS
☐ Cardiac pacemaker	☐ Epilepsy	☐ Lung Disease	☐ Diabetes (Type 1 / Type 2)
☐ HIGH / LOW blood pressure	☐ Prosthetic transplants	☐ Radiation Therapy	☐ Rheumatic fever
☐ Angina	☐ Tuberculosis	☐ Cancer	☐ Thyroid disease

How are you feeling about your visit today? (please circle)

At Ease 1 2 3 4 5 6 7 8 9 10 Very Anxious

How happy are you about your teeth? (please circle)

Very Unhappy 1 2 3 4 5 6 7 8 9 10 Very Happy

How did you hear about us? (please circle)

Google online search Facebook Signage Newsletter QLD Health Referred by friend: _____

Please note:

- ✓ Payment is required at the end of all visits, as we do not operate accounts.
- ✓ The information you have provided is handled in accordance with the Privacy Policy established by the Australian Dental Association.
- ✓ If you must cancel your appointment, we require 24 hours' notice or a cancellation fee may apply.
- ✓ You are giving consent to be examined and/or treated by our dental staff.

Patient Signature: _____ Date: _____/_____/2019

Parent/Guardian name (if under 18): _____

Viewed and updated _____ Date: _____/_____/_____

List of Medications:
