# NEW PATIENT AND MEDICAL HISTORY QUESTIONNAIRE

We are pleased to welcome you to our practice. Please complete the form. The following information is necessary to enable us to provide you with your best dental care. All information disclosed is confidential.

Title Dr / Mr / Mrs / Miss / Ms / Other

First name _____ Surname _____ Age _____DOB _____

Address_____

Suburb _____ Postcode _____

Phone (Home) _____ Phone (Mobile) _____

Occupation _____

Email: _____

Health fund for dental cover _____ Membership No. _____

Medicare Card No. _____ Veterans' Affairs Card No._____

Emergency Contact _____ Relationship to patient _____

Contact No _____

**Person responsible for account- must be completed if patient under 16, if same as above tick here** ☐

Name _____ Relationship to patient _____

Address _____ Postcode _____

Phone (Mob) _____ (Hm) _____ (Wk) _____

If third party, insurance company/employer responsible for account _____

**HEALTH DETAILS**

**Past/Current medical conditions:**

Are you receiving any medical treatment at present Y/N Details _____

Have you had any serious or long standing illness Y/N Details_____

Have you been recently hospitalised Y/N Details_____

**Please indicate if you have EVER had any of the following:**

| | | | |
|---|---|---|---|
| Any heart complaint/treatment | Y/N | Gastric ulcer | Y/N |
| Rheumatic fever or heart valve surgery | Y/N | Asthma/Bronchitis/Lung conditions | Y/N |
| High or low blood pressure | Y/N | Radiation therapy/ chemotherapy | Y/N |
| Blood Disorders | Y/N | Fainting or dizziness | Y/N |
| Anti-coagulant therapy | Y/N | Hepatitis, jaundice or liver disease | Y/N |
| Joint replacement surgery | Y/N | Treatment for any form of cancer | Y/N |
| Osteoporosis or low bone density | Y/N | Pregnant ( when due) _____ | Y/N |
| Epilepsy | Y/N | Do you bruise or bleed easily? | Y/N |
| Diabetes Type 1 \| Type 2 | Y/N | Other _____ | |
| HIV/AIDS/HEP B OR C | Y/N | Do you smoke | Y/N |

**Current medications** (prescription, over the counter, herbal )

_____

_____

_____

_____

**Allergies ( eg. Penicillin, sulphur, codeine, latex)** Y/N Details_____

**Medical Practitioner**_____

**Suburb**_____

**YOUR DENTAL HISTORY**

What is the reason you have come to see me today? _____

How long is it since you have seen a dentist? _____

How long has it been since you have had dental x-rays?_____

Does food catch regularly in particular places between your teeth? Y/N

Do your gums bleed when brushing? Y/N

Are any of your teeth loose? Y/N

Are any of your teeth sensitive to hot, cold or pressure or tooth brushing? Y/N

Are you aware of having any broken teeth? Y/N

Have you had your wisdom teeth removed? Y/N

Have you had any abnormal reactions to local or general anaesthesia? Y/N

Do you normally require Antibiotic cover before dental treatment? Y/N

Do you have any Crowns/ Dentures/ Plates Y/N Details: _____

When was your last scale and clean? _____

How do you feel about having dental treatment at this surgery today? Please tick

Extremely Nervous Moderately Nervous

Mild case of nerves Relaxed and Confident

How did you hear about us? _____

ALL PATIENTS/GUARDIAN TO READ AND SIGN:

I acknowledge that in the event that I attend Dental @ Campbelltown and do not have private health insurance or I have insufficient private health insurance, all dental treatment will be payable by me (the patient) on the day of which the service is provided.

Print Patient / Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____