PATIENT PERSONAL & MEDICAL QUESTIONNAIRE
PRIVATE & CONFIDENTIAL

Welcome to our Practice
Please answer these questions as completely as possible. It will greatly assist us to provide the best dental treatment for you

Macintyre Dental

YOUR DETAILS

Title: _____ First Name: _____ Surname: _____ Date of Birth: _ _/_ _/_ _ _ _

Home Address: _____City: _____ Postcode _ _ _ _

Phone Home: ( ) _____Mobile: _____ Email: _____

Occupation: _____ Employer: _____ Phone (Work): ( ) _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Are you in a Private Health fund with **Dental Extras**? _____ If *Yes*, which one? _____

Other, please circle: Veterans Affairs Medicare Child Dental Benefit Scheme Qld Health

Please circle how you heard about us

Word of Mouth Friend/Family	Referral from staff member	Social Media Facebook etc	Google Search	Free Times Advert	School Visit From Sue/Ruby	Dr/Specialist Referral	Phone Book	Other- _____

DENTAL HISTORY

When was your last dental examination and clean? (approx.) _____

Are you currently experiencing pain or a specific dental problem? YES / NO

Details _____

Are you nervous, anxious or have you ever had a bad experience at a dental visit? YES / NO

Details _____

Are you happy with the appearance of your teeth and smile? YES / NO

Details _____

Do you have bleeding gums or have you ever been diagnosed with or treated for gum disease? YES / NO

How frequently do you **brush** your teeth? **ONCE A DAY** / **TWICE A DAY** / Other _____

How frequently do you **floss** or use brushes to clean between your teeth? **DAILY**/ **WEEKLY** / Other _____

Is there anything you would like to talk to your dentist about that you are not comfortable writing on this form? YES / NO

Would you like to discuss or find out more about any of the following: (please tick)

Replacement of missing teeth		Crooked Teeth	
Removal of wisdom teeth		Tooth grinding / Clenching	
Bad breath		Bleeding gums	
Dentures		Implants	
Crowns		Veneers	
Root canal treatment		Whitening	
Cosmetic appearance of teeth		Facial Aesthetics	
Other (please specify):-			

PLEASE TURN FORM OVEr

MEDICAL HISTORY DETAILS

Doctors Name: _____Name of Doctors Practice: _____

Are you currently being treated by a Doctor? YES/NO Have you ever had a reaction to local or general anaesthetic? YES/NO

Do you normally require antibiotic cover before dental treatment? YES/NO

Do you currently smoke? YES/NO Have you ever smoked? YES/NO Approx. date if quit: _____

*__**FEMALES**__: Are you pregnant or is there a chance you could be pregnant? YES/NO If **YES**, how many weeks ____

Please list any drugs or medicines you are allergic to: _____

Please list any other know allergies (*including latex, food, preservatives*): _____

Please list any prescriptions or other medications you are currently taking: _____

_____

(If you are in any doubt about your medication, please bring a Pharmacy Medication Summary or the bottle or packet(s) to the practice to show the dentist)

Please indicate YES or No if you have ever had any of the following:

CONDITION	YES	NO	CONDITION	YES	NO
Rheumatic fever			Thyroid disease (including goitre)		
Heart condition/cardiac surgery/pacemaker			Epilepsy/Seizures		
Heart valve replacement			Tuberculosis (TB)		
High or low blood pressure *(If **YES**, circle which one)*			Asthma/Bronchitis/lung conditions		
Blood disorders			Nervous system disorder		
Excessive bruising or bleeding			Anxiety/Depression		
Hepatitis, jaundice or liver disease			Gastroesophageal reflux disease (GORD)		
Kidney/renal disease			Transplanted organ/bone marrow/stem cells		
Diabetes or family history of diabetes			Chemotherapy/Radiation therapy		
Osteoporosis or low bone density			Stomach/Digestive Conditions		
Rheumatoid arthritis/Lupus (SLE)/Polymyalgia			Anaemia/Leukaemia		
Joint replacement surgery			Treatment for cancer (*type/region*)		
Jaw, neck or shoulder injury or pain			Snoring/Sleep Apnoea		

DECLARATION:

In signing this form I acknowledge that this represents an accurate medical history. I will advise my dentist of any changes to my medical history in the future. I understand that all medical details will be treated with complete professional confidentiality.
I have read the privacy document provided by this practice.

Patient Signature: _____ Date: _____
Parent or guardian if under 18 years

PRIVACY STATEMENT: We value your privacy. All of the information which you provide to us will be held and used by us in accordance with our Privacy Policy. A copy of our Privacy Policy is attached to this Questionnaire. Please take the time to read through our Privacy Policy before answering the Questionnaire and speak to one of our staff members if you have any concerns about how we will use your personal information.