

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

YOUR DETAILS

Title: ___ First Name: _____ Surname: _____ Sex: ___ Date of Birth ___/___/___

Home Address: _____ City: _____ Postcode _____

Phone Home: () _____ Mobile: _____ Email: _____

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

Emergency Contact Name: _____ 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

Do you identify as: A person of Aboriginal and Torres Strait Islander origin, please circle: **YES / NO / PREFER NOT TO SAY**

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 or 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 uncomfortable 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	<input type="checkbox"/>	Crooked Teeth	<input type="checkbox"/>	Crowns	<input type="checkbox"/>	The cosmetic appearance of your teeth	<input type="checkbox"/>
Removal of wisdom teeth	<input type="checkbox"/>	Tooth grinding / Clenching	<input type="checkbox"/>	Root canal treatment	<input type="checkbox"/>	Facial Aesthetics	<input type="checkbox"/>
Bad breath	<input type="checkbox"/>	Bleeding gums	<input type="checkbox"/>	Veneers	<input type="checkbox"/>		<input type="checkbox"/>
Dentures	<input type="checkbox"/>	Implants	<input type="checkbox"/>	Whitening	<input type="checkbox"/>		<input type="checkbox"/>

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 usually require antibiotics before any dental treatment? **YES/NO**

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

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

PLEASE TURN OVER THE PAGE – TO BE CONTINUED >>>>>>>>

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

Please list any other known allergies (including latex, food, and preservatives): _____

Please list any prescriptions or other medications you are currently taking, **INCLUDING INJECTIONS**: _____

(If you are in 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 valve replacement			Epilepsy/ Seizures		
High blood pressure			Tuberculosis (TB)		
Low blood pressure			Bronchitis/ Lung conditions (please circle)		
Excessive bruising or bleeding			Asthma		
Jaundice or Liver disease (please circle)			Anxiety		
Kidney/ Renal disease (please circle)			Depression		
Diabetes or family history of diabetes (please circle)			Transplanted Organ/ Bone marrow/ Stem cells (please circle)		
Blood disorders: Type: _____			Snoring/ Sleep Apnoea (please circle)		
Anaemia/Leukaemia (please circle)			Heart condition/ Cardiac surgery/ Pacemaker (please circle)		
Nervous system disorder			Rheumatoid arthritis/ Lupus (SLE)/ Polymyalgia		
Osteoporosis or low bone density			Hepatitis A, Hepatitis B, Hepatitis C or HIV/ Aids (please circle)		
Joint replacement surgery/ Artificial Joints			Stomach/ Digestive Conditions		
Jaw, neck or shoulder injury or pain			Gastroesophageal Reflux Disease (GORD)		
Treatment for cancer: Type/ region: _____			Cognitive Disabilities (E.g. ADHD, ASD) Please specify: _____		
Have you had radiation or radiation therapy to the head or neck? If YES, Why was the radiation therapy performed? _____			Suffer from Addiction If YES, please provide details. _____		
When did you receive the radiation? _____					
Other conditions: (Please specify) _____					

DECLARATION:

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

- I understand that my dentist is operating their own practice at Granite Belt Dental & MacIntyre Dental, and Granite Belt Dental & MacIntyre Dental is not controlled by my Dentist.
- I understand that my dentist is using these rooms at Granite Belt Dental & MacIntyre Dental on the basis of a lease and facility agreement with Granite Belt Dental & MacIntyre Dental.
- I acknowledge that if there are any complaints about the treatment, I understand that the dentist who provided the treatment is the person responsible for resolving these complaints and or any liability that arises from the provision of the treatment.
- I also understand that any complaints should be directed to my dentist by contacting Granite Belt Dental & MacIntyre Dental by telephone, email or in person.

Patient Signature: _____ **Date:** _____

Parent or guardian if under 18 years.

PRIVACY STATEMENT: We value your privacy. All 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.