New Patient Dental & Medical Questionnaire

All information on this form is, and will remain, strictly confidential under the Privacy Act 1988*

Patient information

Surname: _____

Given names: _____

Title: _____

Date of birth: / / _____

Occupation: _____

Address: _____

Postcode: _____

Phone: _____ ☐ *Preferred contact for appointment reminder (please tick one)*

Mobile: _____ ☐

Other phone: _____ ☐

Email: _____

Emergency contact person

Name: _____

Phone: _____

Health fund information (if applicable)

Fund name: _____

Parent / Guardian detail (if you are under 18)

Name: _____

Address: _____

Phone: _____

Referral information – how did you find us?

☐ Internet ☐ Walk in ☐ Yellow Pages ☐ Family member recommended ☐ Friend recommended ☐ Other→_____

Medical history

Have you ever had, or do you suffer from, any of the following? Please tick those that apply:

- ☐ Anaemia / Blood disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood pressure
- ☐ Bone disease / Osteoporosis
- ☐ Brain shunt / injury / surgery
- ☐ Cancer / Chemotherapy
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive bleeding
- ☐ Fainting disorder
- ☐ Gastric banding / Lap band
- ☐ Heart disease / Murmur / Stent
- ☐ Hepatitis A / B / C
- ☐ Immune disorders
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease
- ☐ Pacemaker
- ☐ Prosthetic
- ☐ Prosthetic implant / Joint replacement
- ☐ Psychiatric condition
- ☐ Radiation therapy
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Steroid therapy
- ☐ Stomach issues
- ☐ Stress disorders
- ☐ Stroke
- ☐ Surgery
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Tumours

How do you rate your overall GENERAL HEALTH? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

*If you respond '**yes**' to any questions in this group, **please provide more information in the space provided**.*

Are you currently taking any pills, medications, or supplements? ☐ No ☐ Yes→ _____

Do you have any allergies to antibiotics, medications, or other substances? ☐ No ☐ Yes→ _____

Have you had any serious illnesses in the past two years? ☐ No ☐ Yes→ _____

Are you expecting to undergo any surgery or treatment in the next six months? ☐ No ☐ Yes→ _____

Have you ever taken any medication for any bone disorder? ☐ No ☐ Yes→ _____

Do you have any other medical conditions that you have not listed above? ☐ No ☐ Yes→ _____

Do you smoke cigarettes or other recreational drugs? ☐ No ☐ Yes→ *How many per day?* _____

Females please also answer these questions:

Are you currently, or do you think you might be, pregnant? ☐ No ☐ Yes→ *Likely due date:* _____

Are you currently breastfeeding? ☐ No ☐ Yes

...continued overleaf...

Consent for contacting General Medical Practitioner

*For the purposes of maintaining and collecting accurate information about your health and in accordance with our Privacy Policy, it is necessary **at times** to be able to contact your Medical Doctor directly, in order to carry out your treatment safely and effectively.*

I, the undersigned, give my Dental Practitioner at Wolf Kropf Dental Surgery, permission to contact my General Practitioner or Specialist, **if required**, in the course of my dental treatment, to obtain or discuss issues that are relevant to my health.

I understand that this will be done in accordance with the *Privacy Act 1988** and will be confidential.

Patient/parent/guardian signature: _____ Date: / /

GP name: _____ GP contact phone: _____

Dental history

If you are experiencing any of the following, please TICK ☑ those that apply. If you are concerned about any of the following, please CIRCLE ◯ those that apply:

- ☐ Sensitivity to hot or cold
- ☐ Bleeding gums
- ☐ Discoloured fillings
- ☐ Headache or neck ache
- ☐ Food trapping between your teeth
- ☐ Staining of your teeth
- ☐ Pain on biting
- ☐ Impaired ability to eat
- ☐ Bad breath
- ☐ Grinding or clenching
- ☐ Loose or ill-fitting dentures
- ☐ Dry mouth
- ☐ Missing teeth
- ☐ Worn / broken teeth
- ☐ Tooth ache
- ☐ Tooth decay
- ☐ Clicking or pain in the jaw
- ☐ Problems with previous dental treatment
- ☐ Problems with existing crowns or bridges
- ☐ Rough existing fillings
- ☐ Lost fillings
- ☐ Crooked teeth
- ☐ Gaps between teeth
- ☐ Loose teeth
- ☐ Ulcers / blisters / lumps

Are you attending for a specific problem as listed above? ☐ Yes→ *Please provide more information:* _____ ☐ No

How long ago was your last dental visit? ☐ 6 mths or less ☐ 1 yr ☐ Between 1 & 2 yrs ☐ 2 yrs ☐ Between 2 & 5 yrs ☐ 5 yrs or more

Does dental treatment make you feel nervous? ☐ Never ☐ Slightly ☐ Moderately ☐ Extremely

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No→ *If no, please provide more information:* _____

Have you had your wisdom teeth removed? ☐ Yes ☐ No

Do you wish to be placed on a recall appointment list? ☐ 6 monthly ☐ Yearly ☐ No

Please tick any of the following you use for daily oral health: ☐ Non-fluoridated toothpaste ☐ Fluoridated toothpaste ☐ Interdental brushes ☐ Dental tape / floss ☐ Electric toothbrush ☐ Toothbrush ☐ Toothpicks/Waterpik

Do you drink fluoridated water? (*'town' or 'council' water is fluoridated, bottled or tank water typically is not*) ☐ Yes ☐ No

How many times a day do you brush your teeth? ☐ 4 or more ☐ 3 ☐ 2 ☐ 1 ☐ I don't always brush daily

Consent for service

- I, the undersigned, to the best of my knowledge, have provided accurate information relating to my health, and if any changes are required I will notify the Dentist/Surgery as soon as is practicable.
- I consent to the performing of dental and surgical procedures agreed to be necessary or advisable, and I will assume responsibility for the fees associated with those procedures.
- I am aware that payment is made on the day of service.
- I understand that Wolf Kropf Dental Surgery requires at least 24 hours' notice should I need to cancel my scheduled appointment and that a cancellation fee of $50 per 30 minutes or $100 per 60 minutes may be charged.

Patient/parent/guardian signature: _____ Date: / /

* *A copy of Wolf Kropf Dental Surgery's Privacy Policy, as per the* Privacy Act 1988, *is available upon request.*