DENTAL & MEDICAL QUESTIONNAIRE

CASUARINA SQUARE DENTAL CARE

Title (Mr|Mrs|Master|Miss|Ms|Dr|Other): **D.O.B:** / / **Gender:** ☐ M ☐ F

Given Names:	**Surname:**
Residential Address: **Suburb:** **Postcode:**	**Postal Address:** **Suburb:** **Postcode:**
Home Phone: **Mobile:**	**Work Phone:**

Email: _____ **Occupation:** _____

Private Health: _____ **Member Number:** _____ **Reference #**_____

Name of person / company responsible for fees: _____

Emergency Contact Name: _____ **Number:** _____

Would you be interested in zip money **?** ☐ Yes ☐ No

MEDICAL HISTORY

Doctor's Name: _____

Practice: _____ **Ph:** _____

Do you have any Allergies?

☐ Penicillin ☐ Codeine ☐ Anaesthetic ☐ Latex ☐ Other: _____

Are you pregnant or breastfeeding? ☐ N/A ☐ No ☐ Yes, Due Date: _____

Do you have or have you ever had any of the following conditions? (Please tick all that apply)

☐ Heart Problems	☐ Osteoporosis	☐ Artificial Joints
☐ Rheumatic Fever	☐ Stomach Ulcers	☐ Snoring
☐ Pacemaker/Heart Valve	☐ Epilepsy	☐ Diabetes Type I / II
☐ Anaemia/Blood disorders	☐ Asthma	☐ Liver/Kidney problems
☐ Excessive Bleeding/Bruising	☐ Tumour History	☐ HIV
☐ High/Low Blood Pressure	☐ Chemo/Radiotherapy	☐ Hepatitis A / B / C / D / E

Other Medical Conditions: _____

Are you currently taking any medications? ☐ Yes ☐ No

If YES, please list names: _____

_____

_____

DENTAL HISTORY

Please tick all that apply:

- ☐ Does your jaw click or hurt?
- ☐ Do you feel you grind your teeth?
- ☐ Have you ever had orthodontic treatment?
- ☐ Do you have or have you had gum disease?
- ☐ Do you wear a night guard?
- ☐ Do you experience sensitivity with hot/cold?
- ☐ Do your gums bleed when you brush your teeth?
- ☐ Do you experience bad breath?

Other dental history: _____

_____

Are you a smoker? ☐ Never ☐ Previous ☐ Current: _____ per day for the last _____ years

Are you interested in teeth whitening? ☐ Yes ☐ No

How long since your last dental appointment? ☐ 6 months ☐ 1 year ☐ 2 years ☐ More

How often do you have dental examinations? ☐ 6 monthly ☐ Yearly ☐ 2 yearly ☐ Others

Previous dental x-rays were taken: ☐ Less than a year ago ☐ Longer than a year

How did you hear about us?

- ☐ Passing By
- ☐ Internet
- ☐ Advertisement
- ☐ Family/Friend
- ☐ Social Media
- ☐ Other: _____
- ☐ Personal Referral (Who?) _____

Consent for treatment

I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of services unless other arrangements have been made and accept responsibility for any debt collection fees. I authorise that this data may be reviewed by team members of the dental practice.

Patient Signature _____ **Date:** _____

Responsible Party's Signature_____ **Relationship to Patient** _____

This is NOT a Government Health Clinic. We DO NOT Bulk Bill