Beautiful Teeth easy as...
123Dental

DENTAL QUESTIONNAIRE
WELCOME TO OUR PRACTICE

NAME (Mr/Mrs/Ms/Miss/Dr/Other).....
(First Names) (Family Name)

ADDRESS:.....

DATE OF BIRTH..... PHONE (HOME).....PHONE (WORK) .....

PHONE (MOBILE).....EMAIL.....

OCCUPATION.....EMPLOYER.....

EMERGENCY CONTACT.....RELATIONSHIP.....CONTACT NO.....

DO YOU HAVE DENTAL PRIVATE HEALTH COVER? Y / N Fund ..... Membership Number .....

PENSION/ HEALTH CARE CARD NO.....CARD EXPIRY DATE.....

HOW WILL YOU BE SETTLING YOUR ACCOUNT TODAY? Cash / Cheque / Credit Card / EFTPOS / Other.....

WHO CAN WE THANK FOR REFERRING YOU TO US? .....

PRIVATE AND CONFIDENTIAL MEDICAL QUESTIONNAIRE
THE STATE OF YOUR HEALTH MAY HAVE A SIGNIFICANT EFFECT ON YOUR DENTAL CARE
PLEASE ANSWER THESE QUESTIONS AS COMPLETELY AS POSSIBLE

- **Are you receiving any medical treatment at present N ☐ Y ☐ Details.....**
- **What is the name of your medical practitioner/specialist?.....Phone:.....**
- **Have you been in hospital within the last 5 years? N ☐ Y ☐ Details.....**
- **ALLERGIES Nil known ☐ Y ☐ Details.....**
- **CURRENT MEDICATION (including oral contraception, HRT, naturopathic, herbal and 'over the counter' medicines)**

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PLEASE INDICATE IF YOU HAVE EVER HAD ANY OF THE FOLLOWING BY CIRCLING YES OR NO:

WHEN WAS YOUR LAST DENTAL VISIT?.....		NERVOUS SYSTEM DISORDER	Y N
ANY CARDIAC (HEART) COMPLAINT/ TREATMENT YEAR:.....	Y N	TUBERCULOSIS (TB)	Y N
RHEUMATIC FEVER OR HEART VALVE SURGERY	Y N	ASTHMA	Y N
BLOOD PRESSURE HIGH..... LOW.....	Y N	LUNG CONDITIONS	Y N
BLOOD DISORDERS	Y N	SNORING OR SLEEP APNOEA	Y N
ANTI-COAGULANT (BLOOD THINNING) MEDICATION	Y N	THYROID DISEASE (INCLUDING GOITRE)	Y N
EXCESSIVE BRUISING OR BLEEDING	Y N	RADIATION THERAPY/ CHEMOTHERAPY DATE COMPLETED.....	Y N
OSTEOPOROSIS OR LOW BONE DENSITY	Y N	HEPATITIS, JAUNDICE OR LIVER DISEASE	Y N
BISPHOSPHONATE TREATMENT	Y N	AIDS OR HIV	Y N
JOINT REPLACEMENT SURGERY JOINT..... YEAR.....	Y N	DRY MOUTH	Y N
DIABETES TYPE: ..... FAMILY HISTORY OF DIABETES	Y N Y N	DO YOU SMOKE? Y N WHEN DID YOU QUIT..... IF YES, FOR..... YEARS HOW MANY PER DAY.....	
EPILEPSY	Y N	ARE YOU PREGNANT? Y N ARE YOU BREASTFEEDING?	Y N
GASTRIC ULCER	Y N	HAVE YOU HAD TOOTH WHITENING PREVIOUSLY? YEAR.....	Y N
DEPRESSION/ ANXIETY DISORDER	Y N	WOULD YOU LIKE TO IMPROVE THE APPEARANCE OF YOUR SMILE?	Y N

IN SIGNING THIS FORM I ACKNOWLEDGE THAT THIS REPRESENTS AN ACCURATE MEDICAL HISTORY
I UNDERSTAND THAT ALL MEDICAL DETAILS WILL BE TREATED WITH COMPLETE PROFESSIONAL CONFIDENTIALITY
I AGREE TO ACCEPT ANY COST OR FEE INCURRED DIRECTLY OR INDIRECTLY BY 123 DENTAL FOR THE RECOVERIES OF MONIES DUE TO AN OUTSTANDING ACCOUNT

SIGNED ..... DATE: ..... REVISION DATE: .....
(If under 18 years of age, Parent/ Guardian to sign and complete the below)

PARENT/GUARDIAN ..... TEL: ..... MOBILE: .....
(Print Full Name)

ADDRESS .....