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wanniassa dental surgery

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New Patient Questionnaire

(All information will be treated with complete confidentiality)

Title: Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐

Surname: First Name:

Address:

Home Phone: Work Phone:

Mobile Phone: Date of Birth:

Email:

Who is responsible for your fees?:

Name of health fund?

Current Medical Practitioner:

Primary reason for your visit today:

Please indicate any medical condition for which you are currently being treated:

Please list any medication, prescribed or recreational drugs you are presently taking:

Have you ever taken medication for Osteoporosis?

Please indicate if you have ever suffered from any of the following:

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Asthma or TB
- ☐ Rheumatic Fever
- ☐ Diabetes or Epilepsy
- ☐ Hepatitis
- ☐ Excessive Bleeding
- ☐ Thyroid Problems
- ☐ Kidney Problems
- ☐ Stroke

If you have suffered from any of the above, please provide details:

Are you allergic or have you suffered an adverse reaction to any of the following:

- ☐ Penicillin
- ☐ Asprin or Codene
- ☐ Local Anaesthetics
- ☐ Valium

Other Medications or Antibiotics:

Do you have any other conditions you think we should know about?

Women: Are you pregnant? YES ☐ NO ☐

Hepatitis and AIDS are contagious disease that can be transmitted through blood and saliva. This means dentists and their staff can be in a vulnerable position when treating patients who fall into a "high risk" category. These "high risk" categories have been identified as:

Patients who have contracted Hepatitis B
Recipients of blood or blood products
Homosexuals or bisexuels and their partners or children
Invravenous drug users

Please indicate if you are in any of the above categories so that we can take special steps to protect you, other patients and staff if necessary.

☐ NO - I am not in the "High Risk" Category
☐ YES - I am in the "High Risk" Category

Do you have any problem with any of the following?

☐ Bleeding Gums
☐ Bad Breath
☐ Cleanching or Grinding your teeth
☐ Chronic headache, face ache or earache
☐ A clicking or painful jaw joint
☐ Sensitivity to temperature or pressure
☐ Worn or broken teeth
☐ Does the appearance of your teeth worry you?
☐ Difficulty in opening widely
☐ Have you ever had surgery or deep x-ray therapy for a tumour, growth or other condition to your head or neck?
☐ Have you ever had trouble/reactions associated with previous dental treatment?
☐ Do you feel apprehensive or nervous about dental treatment?

What worries you most about your teeth?

How did you find us?

If you were referred, who may we thank?

Please note: The practice will charge a "Cancellation fee" if notification is received less than 24 hours from the time of the appointment. The practice will charge a "Fail to Attend fee" if appointment is missed completely.
Accounts referred to a collection agency or solicitor will have all legal cost & commission added to the amount due.

SIGNED DATE

Thank you for your time to fill in this form. We hope it will help us provide you with the highest standards of treatment.

We take your privacy & the security of your information seriously. To read our full privacy policy, visit mavendental.com.au/privacy-policy or ask our team for a copy