New Patient Questionnaire

In order to provide you with high quality dental care tailored to your needs, we need to collect some personal information regarding your medical history. Your medical history is important as it could affect the outcome of your dental treatment. If you have any questions regarding the information we collect from you, please do not hesitate to ask. All information will be kept confidential.

Prof Dr Fr Mr Mrs Ms Miss Master

Full Name ____

Home Address: ____ Postcode: ___________

Telephone: (Home) ___________________ (Work) ____________________ (Mobile) ____________________

Email address: ____

Date of Birth: __________________________

Occupation: ____

Do you have Dental Health Insurance? _____________________________ Name of Fund: ______________

How did you hear about our practice?

- Internet
- Live locally
- Hospital
- Family/Friend - If so, who can we thank ___________________
- Doctor
- Dentist
- Yellow pages
- Other – Please specify ___________________________

Dental History

When was your last Dental checkup?____

Previous dental x-rays were taken: O Less than one year ago O More than one year ago

Do you have any Dental concerns? ____

____

Have you experienced any of the following?

- Orthodontic Treatment
- Jaw clicking or pain
- Teeth grinding or clenching
- Do you wear a night guard?
- Bleeding gums
- Bad breath / Bad taste
- Sensitivity to hot or cold
- Food catching between your teeth

Any other information you feel is important:____

____

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Dr Ross Martin | Dr John Martin | Dr Jae Pease | Dr Richard Moule | Dr Jason Small | Ms Christie Annand

Medical History

COORPAROO family dental
Est. 1950

Please list all medications (including supplements) you currently take: ____

____

____

Please list all known allergies (eg. Penicillin, latex etc): ____

Do you have, or have you ever had any of the following medical conditions?

- Rheumatic Fever
- Epilepsy
- High or Low blood pressure
- Cardiac Pacemaker
- Infectious Disease
- Excessive Bleeding
- Artificial joint or implant
- Stomach or digestive problems
- Osteoporosis
- Steroid Therapy
- Asthma
- Bone Medication
- Treatment for cancer
- Radiation Therapy
- Heart valve disorder or heart murmur
- Heart Condition
- Sinus Trouble
- Anaemia or other Blood conditions
- Diabetes
- Kidney or Liver Disease

Any other conditions: ____

Are you a smoker? O Yes O No

Are you/could you be pregnant? O Yes O No

Emergency Contact: ____ Phone: ________________________

Name of your Medical Practitioner: _____________________________________ Phone: ________________________

Practice Address: ____

I acknowledge that the information I have provided is true and correct.

Patient/ Guardian signature: ____ **Date:** _________________

Dentist signature: ____ **Date:** _________________

Medical history updated: ____ **Date:** _________________