PATIENT PERSONAL & MEDICAL QUESTIONNAIRE   PRIVATE & CONFIDENTIAL

Welcome to **Belmont Dental Surgery**

These questions are set by the ADA; please answer them as completely as possible. It will greatly assist us to provide the best dental treatment for you.

Title………First Name………………Preferred Name…….........Surname……………………DOB………..

Address …………………………………………………………………………Postcode ……………………

Phone (Home) ...…………....……….Phone (Mobile) …………...

Email………

As a courtesy, we send reminders when further treatment or routine check-ups are due. Please indicate your preferred reminder option **- SMS, Phone, Email, or Letter** please circle the appropriate response.

Occupation …………………………..Employer..…………………………. Phone (Work) ....………………..

Emergency Contact Name.................................Relationship.................................Phone.......................

Which Health Fund do you belong to? ....……………………………………………………………….

How did you hear about our practice? Please specify eg Google……………..……………………………….

If referred by another patient can we have their name to thank them?...........................………………….

The state of your health may have a very significant effect on your dental care.

Please answer these questions fully or discuss them with your dentist:

I have private and confidential medical matters which I wish to discuss with the dentist   Y N

Are you receiving any medical treatment at present? ....   Y N

Name of your medical practitioner / specialist ....……………………………........................

Some medicines may interfere with your dental treatment or react with medicaments used by your dentist. It is important that your dentist knows precisely what medications (if any) that you are taking.

Please indicate by circling Y (YES) if you are taking any of the following, or N (NO) if not:

Please provide details (inc. dose and frequency) of any medicine or medication that you are currently taking, or have been taking recently. This should include:

Y N Aspirin..

Y N Warfarin or Heparin or other blood thinning medicine...

Y N Oral contraceptive...

Y N Hormone Replacement Therapy...

Y N Cortisone or steroids...

Y N Medication for depression (MAOIs, SSRIs or Tricyclics) ……………………………………………………

Y N Treatment for osteoporosis (Bisphosphonates, Prolia)...

Y N Any other prescription medication...

Y N Any herbal or naturopathic medications ....

Y N Any 'over the counter' medications..

If you are in any doubt about your medication, please bring the bottle or packet(s) to the practice to show the dentist.

Have you ever had an allergic reaction to any medicine (inc. Penicillin or other antibiotic), foods, chemical or substance (such as chlorine/latex/antiseptics/elastoplast)? If yes please give details

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PLEASE TURN OVER

Please indicate by circling <u>Y (YES)</u> if you have ever had any of the following, or <u>N (NO)</u> if not:

Rheumatic Fever....................................	Y N	Joint replacement surgery ………………..	Y N
Any heart (cardiac) complaint/treatment	Y N	Neck/Jaw or Shoulder damage or pain ….	Y N
Cardiac pacemaker ……………………….	Y N	Epilepsy (Fits) ………………………………	Y N
Heart valve replacement ………………….	Y N	Thyroid disease (Including goitre) ………….	Y N
High or low blood pressure **(circle which)…**	Y N	Tuberculosis (TB) …………………………….	Y N
Anti-coagulant (blood thinning) ………….	Y N	Asthma/bronchitis/lung conditions ………..	Y N
Blood disorders ……………………………	Y N	Any nervous system disorder ………………	Y N
Excessive bruising or bleeding ……………	Y N	Anxiety/Depression …………………………	Y N
Osteoporosis or low bone density ……..	Y N	Gastroesophageal reflux disease (GORD) ..	Y N
Diabetes or family history of diabetes …….	Y N	Inflammatory Bowel disease ………………	Y N
Hepatitis, jaundice or liver disease ………..	Y N	Transplanted organ/bonemarrow/stem cells	Y N
Urinary tract/Kidney disease ……………..	Y N	Snoring/Sleep Apnoea ……………………..	Y N

Have you ever smoked? Y or N Approx date if Quit ....../....../.....…………………………………

If you currently smoke how much do you smoke per day ....and for how long..............................

Have you ever required any treatment for smoking related diseases or conditions? Y or N

Do you suffer from any illness not listed above or carry any infectious disease? Y or N

If yes, please provide details..

Have you ever had chemotherapy or radiation treatment for cancer? If yes please give details of type & region

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Illicit substances including Cannabis, Methamphetamine, Heroin & Cocaine may impact your oral health & can potentially cause adverse reactions to certain dental procedures. We advise that you are honest & inform your dentist about such drug use, all information will be treated in the strictest confidence.

Are you/do you suspect you may be Pregnant? Y or N If yes, please specify due date? ....

Are you breastfeeding? Y or N

DECLARATION:

In signing this form I acknowledge that this represents an accurate medical history.
I will advise my dentist of any changes to my medical history in the future.
I understand that all medical details will be treated with complete professional confidentiality.
I have read the privacy document provided by this practice.

Payment for treatment is required on the day; we accept cash, debit card or credit card.

We require 24 hours notice for cancellations and changes to appointments.
Missed appointments and late cancellations will be charged at $75 per 15 minute block.

Patient Signature …………………………………………....................... Date …………………………………
(Parent or guardian if under 18 years)