BELMONT DENTAL SURGERY PATIENT PERSONAL & MEDICAL QUESTIONNAIRE

Please answer questions fully *(in black/blue ink)* to assist us in providing the best & safest treatment for you.

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

Address……………………………………………………………………………Postcode...……………………...

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

Email……………………....................................... Occupation …………………………………………………..

To comply with our privacy policy, our preferred methods of contacting you are SMS for recalls & reminders and secure email for records, x-rays etc. Please let reception know if this is problematic for you.

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

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

How did you hear about our practice? Please specify e.g. 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 (please circle **YES(Y)** or **NO(N)**):

Have you had dental x-rays taken elsewhere within the last 12 months? **Y N** Approximate date:……………...

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 general 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 list any medications you are currently taking, or have been taking recently including herbal remedies, vitamins, supplements, cold/flu treatments, sleeping pills, pain relievers, injections or implants, so we can take appropriate precautions and avoid drug interactions.

For example: Aspirin, Contraceptives, Hormone Replacement Therapy, Steroids, Anti-depressants, Bisphosphonates/Prolia and St John's Wort.

DRUG NAME	DOSAGE	DURATION OF TREATMENT	PURPOSE/CONDITION

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

……………………………………………………..……………………………………………………………………

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

****PLEASE DATE, THEN TURN OVER TO COMPLETE THE OTHER SIDE OF THIS FORM****

Date:…………………………......

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

Rheumatic Fever .... **Y N**
Any Heart (cardiac) complaint/treatment… **Y N**
Cardiac pacemaker ………………………. **Y N**
Heart valve replacement …………………. **Y N**
HIGH or **LOW** blood pressure **(circle which)** **Y N**
Anti-coagulant (blood thinning) …………… **Y N**
Blood disorders ……………………………… **Y N**
Excessive bruising or bleeding ……………. **Y N**
Osteoporosis or low bone density ……….. **Y N**
Diabetes or **Family History** **(circle which)** **Y N**
Hepatitis, jaundice or liver disease ……….. **Y N**
Urinary tract/Kidney Disease ……………… **Y N**

Joint replacement surgery ………………….. **Y N**
Neck/Jaw or Shoulder damage or pain …… **Y N**
Epilepsy/Seizures (Fits) …………………… **Y N**
Thyroid disease (including goitre) ………… **Y N**
Tuberculosis (TB) ……………………………. **Y N**
Asthma/bronchitis **(circle which)** …………….**Y N**
Any nervous system disorder ……………… **Y N**
Anxiety/Depression …………………………. **Y N**
Gastroesophageal Reflux Disease (GORD) **Y N**
Inflammatory Bowel Disease (IBS)………… **Y N**
Transplanted organ/bonemarrow/stem cells **Y N**
Snoring or Sleep Apnoea **(circle which)**…… **Y 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/radiation treatment for cancer? If **yes** please give details of type & region

……...

Non-prescription or recreational drugs, for example; Tobacco, Alcohol, Cannabis, Ecstasy, Cocaine Methamphetamine and Heroin can impact negatively on your oral health. Please be honest and inform your dentist about such drug use, all information will be treated in the strictest confidence.

Have you ever smoked? **Y** or **N** Approximate date if quit ..../........./......…………………………………………

If you currently smoke how many do you smoke per day .... for how many years ....

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

Do you regularly consume more than 14 units of alcohol per week? **Y** or **N**

If you have you used other recreational drugs please circle when? **Recently** or **More than 6 months ago**

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 and update annually.**
- **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)

Belmont Dental Surgery
171 Belmont Avenue,
Belmont WA 6104
Tel 08 9277 3837
Fax 08 9277 2500

info@belmontdental.com.au
www.belmontdental.com.au

RECORDS REQUEST FORM

Your dental history is important to us. If you are new to Belmont Dental Surgery, or have seen another dentist since your last visit here, access to the notes and x-rays can assist in your diagnosis and treatment.

Please complete and sign this form to allow us to request these records.

To: **Dental Practice Name:** ……………………………………………………………………………………………

Address: ………

Suburb: ………

State: …………………………………………………… **Postcode:** …………………………………………………

Re: **Patient Name:** ……………………………………………………………………………………………………

Address: ………

Suburb: ………

State: …………………………………………………… **Postcode:** …………………………………………………

Telephone number: …………………………………………………………………………………………………

Dear Dr,

Could you please release my records and radiographs to Belmont Dental Surgery at the above postal address. Digital images or records can be emailed to info@belmontdental.com.au.

Kind Regards

Signature: ………………………………………………… **Date:** …………………………………