HOPKINS DENTAL New Patient Dental & Medical Questionnaire

*All information on this form is, and will remain, strictly confidential under the Privacy Act 1988**

Patient information

Surname: ______

Given names: ______

Title: ______

Date of birth: ___ / ___ / ___

Occupation: ______

Address: ______

Postcode: ______

Phone: ______ ☐

Mobile: ______ ☐

Other phone: ______ ☐

Preferred contact for appointment reminder (please tick one)

Email: ______

Emergency contact person

Name: ______

Phone: ______

Health fund information (if applicable)

Fund name: ______

Parent / Guardian detail (if you are under 18)

Name: ______

Address: ______

Phone: ______

Referral information – how did you find us?

☐ Internet ☐ Walk in ☐ Yellow Pages ☐ Family member recommended ☐ Friend recommended ☐ Other: ______

Medical history

Have you ever had, or do you suffer from, any of the following? Please tick those that apply:

☐ Anaemia / Blood disease	☐ Epilepsy	☐ Liver disease	☐ Steroid therapy
☐ Arthritis	☐ Excessive bleeding	☐ Lung disease	☐ Stomach issues
☐ Asthma	☐ Fainting disorder	☐ Pacemaker	☐ Stress disorders
☐ Blood pressure	☐ Gastric banding / Lap band	☐ Prosthetic	☐ Stroke
☐ Bone disease / Osteoporosis	☐ Heart disease / Murmur / Stent	☐ Prosthetic implant / Joint replacement	☐ Surgery
☐ Brain shunt / injury / surgery	☐ Hepatitis A / B / C	☐ Psychiatric condition	☐ Thyroid disease
☐ Cancer / Chemotherapy	☐ Immune disorders	☐ Radiation therapy	☐ Tuberculosis
☐ Diabetes	☐ Kidney disease	☐ Rheumatic fever	☐ Tumours
		☐ Sinus problems	

How do you rate your overall GENERAL HEALTH? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

If you respond 'yes' to any questions in this group, please provide more information in the space provided.

Are you currently taking any pills, medications, or supplements? ☐ No ☐ Yes → ______

Do you have any allergies to antibiotics, medications, or other substances? ☐ No ☐ Yes → ______

Have you had any serious illnesses in the past two years? ☐ No ☐ Yes → ______

Are you expecting to undergo any surgery or treatment in the next six months? ☐ No ☐ Yes → ______

Have you ever taken any medication for any bone disorder? ☐ No ☐ Yes → ______

Do you have any other medical conditions that you have not listed above? ☐ No ☐ Yes → ______

Do you smoke cigarettes or other recreational drugs? ☐ No ☐ Yes → How many per day? ______

Females please also answer these questions:

Are you currently, or do you think you might be, pregnant? ☐ No ☐ Yes → Likely due date: ______

Are you currently breastfeeding? ☐ No ☐ Yes

...continued overleaf...

Consent for contacting General Medical Practitioner

For the purposes of maintaining and collecting accurate information about your health and in accordance with our Privacy Policy, it is necessary ***at times*** *to be able to contact your Medical Doctor directly, in order to carry out your treatment safely and effectively.*

I, the undersigned, give my Dental Practitioner at Hopkins Street Dental Surgery, permission to contact my General Practitioner or Specialist, **if required**, in the course of my dental treatment, to obtain or discuss issues that are relevant to my health.

I understand that this will be done in accordance with the *Privacy Act 1988** and will be confidential.

Patient/parent/guardian signature: ______________________ Date: / /

GP name: ______________________ GP contact phone: ______________________

Dental history

If you are experiencing any of the following, please TICK ☑ those that apply. If you are concerned about any of the following, please CIRCLE ☐ those that apply:

- ☐ Sensitivity to hot or cold
- ☐ Bleeding gums
- ☐ Discoloured fillings
- ☐ Headache or neck ache
- ☐ Food trapping between your teeth
- ☐ Staining of your teeth
- ☐ Pain on biting
- ☐ Impaired ability to eat
- ☐ Bad breath
- ☐ Grinding or clenching
- ☐ Loose or ill-fitting dentures
- ☐ Dry mouth
- ☐ Missing teeth
- ☐ Worn / broken teeth
- ☐ Tooth ache
- ☐ Tooth decay
- ☐ Clicking or pain in the jaw
- ☐ Problems with previous dental treatment
- ☐ Problems with existing crowns or bridges
- ☐ Rough existing fillings
- ☐ Lost fillings
- ☐ Crooked teeth
- ☐ Gaps between teeth
- ☐ Loose teeth
- ☐ Ulcers / blisters / lumps

Are you attending for a specific problem as listed above? ☐ Yes → *Please provide more information:* ______________________ ☐ No

How long ago was your last dental visit? ☐ 6 mths or less ☐ 1 yr ☐ Between 1 & 2 yrs ☐ 2 yrs ☐ Between 2 & 5 yrs ☐ 5 yrs or more

Does dental treatment make you feel nervous? ☐ Never ☐ Slightly ☐ Moderately ☐ Extremely

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No → *If no, please provide more information:* ______________________

Have you had your wisdom teeth removed? ☐ Yes ☐ No

Do you wish to be placed on a recall appointment list? ☐ 6 monthly ☐ Yearly ☐ No

Please tick any of the following you use for daily oral health: ☐ Non-fluoridated toothpaste ☐ Interdental brushes ☐ Electric toothbrush ☐ Fluoridated toothpaste ☐ Dental tape / floss ☐ Toothbrush ☐ Toothpicks/Waterpik

Do you drink fluoridated water? (*'town' or 'council' water is fluoridated, bottled or tank water typically is not*) ☐ Yes ☐ No

How many times a day do you brush your teeth? ☐ 4 or more ☐ 3 ☐ 2 ☐ 1 ☐ I don't always brush daily

Consent for service

- I, the undersigned, to the best of my knowledge, have provided accurate information relating to my health, and if any changes are required I will notify the Dentist/Surgery as soon as is practicable.
- I consent to the performing of dental and surgical procedures agreed to be necessary or advisable, and I will assume responsibility for the fees associated with those procedures.
- I am aware that payment is made on the day of service.
- I understand that Hopkins St Dental Surgery requires at least 24 hours' notice should I need to cancel my scheduled appointment and that a cancellation fee of $50 per 30 minutes or $100 per 60 minutes may be charged.

Patient/parent/guardian signature: ______________________ Date: / /

* *A copy of Hopkins Street Dental Surgery's Privacy Policy, as per the* Privacy Act 1988, *is available upon request.*