Patient Personal & Medical Questionnaire

PRIVATE & CONFIDENTIAL

SOUTHWEST DENTAL SPECIALIST CENTRE

Welcome to Southwest Dental Specialist Centre

Please answer these questions as completely as possible. It will greatly assist us to provide the best dental treatment for you. Please ask our staff if you need help with any of the questions. If you are not comfortable asking your question(s) in the waiting room, please ask the practitioner when you enter the surgery.

PRIVACY STATEMENT: We value your privacy. All of the information which you provide to us will be held and used by us in accordance with our Privacy Policy. A copy of our Privacy Policy is attached to this Questionnaire. Please take the time to read through our Privacy Policy before answering the Questionnaire and speak to one of our staff members if you have any concerns about how we will use your personal information.

Name _____

Title First Names Family Name (Preferred Name) If applicable

Address _____

Date of Birth ____/____/____ Phone _____ Alternative Contact Number (Home/Work) _____

Do we have permission to use the alternative contact number if trying to reach you? **Y** ☐ **N** ☐

Email _____

Occupation _____ Medicare Number/Reference _____

Private Health Fund (if applicable) _____ Private Health Fund Number/Series _____

Emergency Contact _____ Relationship _____ Phone _____

Person responsible for payment of accounts _____

If not the patient, please provide address and phone number _____

Whom may we thank for recommending you to our practice? _____

Reason for attending _____

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 indicate **YES** or **NO** if you have ever had any of the following:

	Y	N		Y	N
Dental Anxiety	☐	☐	Jaw, neck or shoulder injury or pain	☐	☐
Heart Condition/Surgery	☐	☐	Musculoskeletal Conditions	☐	☐
Rheumatic Fever	☐	☐	Stroke History	☐	☐
High Blood Pressure	☐	☐	Thyroid Disease (including Goitre)	☐	☐
Low Blood Pressure	☐	☐	Tuberculosis (TB)	☐	☐
Blood Disorders (including HIV and cancers)	☐	☐	Asthma/Bronchitis/Lung Conditions	☐	☐
Excessive Bruising or Bleeding Disorders	☐	☐	Snoring/Sleep Apnoea	☐	☐
Hepatitis, Jaundice or Liver Disease	☐	☐	Psychological Disorders		
Kidney/Renal Disease	☐	☐	(including anxiety and depression)	☐	☐
Diabetes: If yes: Type	☐	☐	Gastrointestinal Disorders (including GORD)	☐	☐
Osteoporosis/Low bone density/Bone diseases	☐	☐	Transplanted Organ/Bone Marrow/Stem Cells	☐	☐
Rheumatoid Arthritis	☐	☐	Cancer: If yes: Type	☐	☐
Lupus (SLE)	☐	☐	Chemotherapy/Radiation Treatment	☐	☐
Connective Tissue Disorders	☐	☐	Joint Replacement Surgery	☐	☐
Skin Disorders (including psoriasis/eczema)	☐	☐	Nervous System Disorder (including epilepsy/seizures)	☐	☐
Do you suffer from any illness not listed above or carry any infectious disease?				☐	☐

If yes, please provide details:

PLEASE CONTINUE TO FINAL PAGE

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

Are you receiving medical treatment at present? **Y** ☐ **N** ☐

Name of your medical practitioner/specialist _____

Practice Name and Phone Number _____

Have you ever been in hospital? **Y** ☐ **N** ☐

If yes, nature of the hospitalisation and dates:

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/supplements (if any) that you are taking.

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

WRITE N/A IF NOT APPLICABLE or bring in your list at the time of your appointment

Name	Dosage	Duration of Treatment	Purpose/Condition

Please list any known **ALLERGIES** or **ADVERSE** reactions to drugs (especially antibiotics e.g. Penicillin), medicines, antiseptics, local anaesthetics, latex, preservatives and food items.

WRITE N/A IF NOT APPLICABLE

Name	Nature of Reaction	How Long Ago

Are you pregnant or is there a chance you could be pregnant? **Y** ☐ **N** ☐ If yes, due date: _____

Are you currently breastfeeding? **Y** ☐ **N** ☐

Have you ever smoked or vaped? **Y** ☐ **N** ☐ Approx date if quit _____ Do you currently smoke or vape? **Y** ☐ **N** ☐

If yes, for how long? _____ How much do you smoke/vape per day? _____

Have you ever used illicit substances and or recreational drugs? **Y** ☐ **N** ☐ If yes, when? Recent ☐ More than 1 year ago ☐

Do you consume alcohol? **Y** ☐ **N** ☐ If yes, how many standard alcoholic beverages _____ /Day ☐ Month ☐ Year ☐

DECLARATION AND CONSENT FOR SERVICE

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 am aware that payment is required on the day of service.
I understand that future appointments cancelled or rescheduled with less than 24 hours notice, a failure to attend the appointment and late arrival to the appointment may incur a fee of $300 for appointments less than an hour in length and $600 for appointments that are an hour in length or longer. Please ask for a copy of our practice's cancellation policy or go to our website at www.swdsc.com.au if you would like further clarification.

Patient Signature _____ Date _____

(Parent or guardian if under 18 years)

Parent/Guardian Name _____