dental on george

132 George Street
East Fremantle
WA 6158
Phone: 08 9339 3047
Fax: 08 9339 4925

# *CONFIDENTIAL PATIENT QUESTIONNAIRE*

This provides the dentist with important information required for your dental treatment and oral health care.

Name: ______________________________________________
Surname First Name Dr / Mr / Mrs / Miss / Ms

Date of birth: ______________________________________________

Home Address: ____________________ Work Address: ____________________

____________________ ____________________

Post Code: ____________________ Post Code: ____________________

Home Phone: ____________________ Work Phone: ____________________

Occupation: ____________________ Mobile Phone: ____________________

Email Address ______________________________________________

Drivers Licence Number (optional) ____________________

Private Health Fund____________________ Reference on the card____________

Are you eligible for Child Dental Benefit Scheme? Yes / No Medicare Number: ____________ Reference: ____

**Details of person to contact in an emergency:**

Name: ____________________ Phone Number: ____________________

Medical Doctors Name: ____________________ Phone (If known): ____________

## MEDICAL HISTORY

1. Are you receiving any medical treatment at present? Yes / No

   Details: ______________________________________________

2. Are you currently taking any medications? Yes / No

   List: ______________________________________________

3. Do you smoke and if so how many a day? Yes / No

   Details: ______________________________________________

4. Are you, or have you been, under the care of a doctor during the past two years? Yes / No

   Reason: ______________________________________________

5. Have you experienced any allergies or unusual effects from any tablets/drugs/injections or anaesthetic? Yes / No

   Details: ______________________________________________

6. Have you ever had any of the following? If so, please tick as appropriate.

- ☐ Rheumatic Fever
- ☐ Heart Trouble/Murmur
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Arthritis
- ☐ Hepatitis - Specify type A, B, C
- ☐ Bronchitis or Chest Problems
- ☐ Severe Headaches
- ☐ Excessive bruising and or bleeding
- ☐ Epilepsy
- ☐ Anaemia
- ☐ Diabetes
- ☐ Kidney Trouble
- ☐ Gastric Problems
- ☐ Cold Sores
- ☐ Depressive Illness
- ☐ Drug Dependence
- ☐ Sinus trouble

**PLEASE TURN PAGE OVER...**

7. Have you had any prosthetic surgery? (E.g. Heart Valve or Hip Replacement) Yes / No
   Details: ______________________________________________

8. Ladies, are you pregnant or breastfeeding? If so, how many months: ______________ Yes / No

9. Are you HIV positive? Yes / No

10. Are you at risk to HIV exposure? Yes / No

## DENTAL HISTORY

Have you had any of the following?

| | | | |
|---|---|---|---|
| Does your jaw click or hurt? | ☐Yes | Do your teeth ever hurt when you bite hard? | ☐Yes |
| Do you feel you grind your teeth? | ☐Yes | Do you think you have occasional bad breath | ☐Yes |
| Have you ever had orthodontic treatment | ☐Yes | Do your gums ever bleed when you brush your teeth? | ☐Yes |
| Do you wear a night guard? | ☐Yes | Do you experience sensitivity with hot/cold | ☐Yes |
| Have you ever had gum disease? | ☐Yes | Does floss ever tear between your teeth? | ☐Yes |
| Have you ever had your bite adjusted? | ☐Yes | Does food get jammed between your teeth? | ☐Yes |
| Do you bite your lips or cheek often? | ☐Yes | | |

How long since your last dental appointment? ______________________

How often do you have dental examinations? ______________________

Would you like Dental on George to provide your future dental treatment? ☐ Yes ☐ No

Do you become anxious or uncomfortable when you are having dental treatment? ☐ Yes ☐ No

**Referred By:**

☐ Yellow Pages Online ☐ Another patient/friend (**Name**) ____________________
☐ Street Sign ☐ Newspaper advertisement
☐ Google search ☐ Other (**Please specify**) ____________________

Is another member of your family a patient at our practice: ☐ Yes ☐ No

**Musical Preference:**

Please state musical genre for your relaxation during treatment: ______________________________

**Patient signature:** ________________________________________ Date: __________

***(Parents to sign if patient is under 18 years of age)***

**Medical history review**

**Patient signature:** ________________________________________ Date: __________

**Patient signature:** ________________________________________ Date: __________

**Patient signature:** ________________________________________ Date: __________