NEW PATIENT DENTAL QUESTIONNAIRE

Please note that all information in this form will remain strictly confidential. Please complete in CAPITAL letters.

Aubin Grove Dental
GENERAL AND COSMETIC

PERSONAL & CONTACT INFORMATION

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname: ..... First Name: .....

Date of Birth: ..... Occupation: .....

Address: ..... Postcode: .....

Phone (H): ..... Phone (W): .....

Phone (M): ..... Preferred Daytime Contact: ☐ Home ☐ Work ☐ Mobile

Email: .....

Emergency Contact Name: ..... Phone: ..... Relation: .....

REFERRAL INFORMATION

Where did you hear about us? ☐ Internet ☐ Walked past ☐ Letterbox Flyer ☐ Cockburn Gazette

☐ Dentist Dr ..... ☐ Patient *(please provide name so that we can thank them)* .....

INSURANCE & PAYMENT INFORMATION

Do you have Health Insurance? ☐ Yes ☐ No Health Fund Name: .....

Preferred payment method: ☐ Cash ☐ EFTPOS ☐ Credit Card

DENTAL HISTORY

Do you have an immediate dental problem? Please describe: .....

Are any of your teeth sensitive to:	☐ Hot	☐ Cold	☐ Chewing	☐ Sweet
Does food tend to get caught in your teeth?			☐ Yes	☐ No
Do your gums bleed or hurt when you clean your teeth?			☐ Yes	☐ No
Do you feel you suffer from bad breath?			☐ Yes	☐ No
How many times a day do you clean your teeth?		☐ Once	☐ Twice	☐ Rarely

Do you clench or grind your teeth?	☐ Yes	☐ No
Do You have a clicking/locking jaw?	☐ Yes	☐ No
Do you get headaches/jaw pain or facial pain?	☐ Yes	☐ No
Have you experienced sore muscles of the jaw neck or shoulders?	☐ Yes	☐ No
Do you wear a night splint/bite plate?	☐ Yes	☐ No

Are you conscious of the colour or appearance of your teeth? ☐ Yes ☐ No

If yes, how would **you** improve the appearance of your smile?

☐ Arrangement? ..... ☐ Colour? ..... ☐ Length? ..... ☐ Shape? .....

Previous general dentist name? .....

Previous x-rays? ☐ Less than 1 year ☐ Longer than 1 year

Please Turn Over

MEDICAL HISTORY

Name of your GP: ..... Your Doctor's Phone No. .....

Your Doctor's address: .....

Have you ever had any of the following? Please tick those that apply:

☐ Anaemia	☐ Excessive Bleeding	☐ Pacemaker
☐ Arthritis	☐ Glaucoma	☐ Psychological Disorders
☐ Artificial Heart Valve	☐ Heart Disease	☐ Radiation Therapy
☐ Artificial Joints (Hip, Knee etc.)	☐ Heart Murmur	☐ Respiratory Problems
☐ Asthma	☐ Hepatitis A,B,C	☐ Rheumatic fever
☐ Blood Disorders	☐ High/ Low Blood Pressure	☐ Sinus Problems
☐ Cancer	☐ HIV/AIDS	☐ Stroke
☐ Diabetes	☐ Kidney Disease	☐ Transplanted Organ
☐ Dizziness/ Fainting	☐ Liver Disease	☐ Tuberculosis
☐ Epilepsy	☐ Osteoporosis	☐ Tumours

Have you had any serious illnesses in the last 2 years? ☐ Yes ☐ No
If yes, please provide more information. .....

Are you currently taking any medications or tablets regularly? ☐ Yes ☐ No
If yes, please provide more information. .....

Are you taking or have you taken any Bisphosphonate Drugs? ☐ Yes ☐ No
If yes, please provide more information. .....

Do you have any allergies to Penicillin, Latex or other drugs? ☐ Yes ☐ No
If yes, please provide more information. .....

Do you smoke? ☐ Yes ☐ No
If yes, how many per day? .....

Females Only:
Are you Pregnant? ☐ Yes ☐ No
If yes, how many months? .....

Are you Breastfeeding? ☐ Yes ☐ No

CONSENT FOR SERVICES

- I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated and I will assume responsibility for the fees associated with those procedures.
- I understand that the practice requires as minimum 24 hours' notice if I need to cancel my scheduled appointment and that a cancellation fee could be incurred if I fail to do so.
- I am aware that payment is required on the day of treatment.

✘ _____ _____

Patient Signature Date of signature