Redcliffe Dental New Patient Questionnaire

So we can ensure we are looking after your needs, please complete the following questionnaire. This information is important as it could affect the outcome of your dental treatment. We keep all information confidential and please don't hesitate to ask us if you have any questions.

Redcliffe Dental
EST 1958

Full Name: _____ Preferred Name: _____
Title *First Name* *Surname*

Date of Birth: _____ Occupation: _____

Address: _____ Phone: _____

Mobile _____ Email: _____

Preferred contact for confirmation of appointments: SMS Email Phone (please circle)

Emergency Contact: _____
Name *Contact Number* *Relationship*

How did you hear about our practice?

- O Internet O Live Locally O Hospital O Dentist O Doctor O Yellow Pages
- O Family/Friend – if so, who can we thank? : _____
- O Other: _____

Do you have any particular dental concerns? _____

Any other information you may feel is important: _____

Do you have Private Dental Insurance? Yes / No Health Fund Name: _____

MEDICAL HISTORY

Are you currently receiving any medical treatment?

Details:

_____
_____
_____

Have you been hospitalised in the last 12 months?

Details:

_____
_____
_____

Please list all medications (including supplements) you currently take:

_____
_____
_____

Redcliffe Dental New Patient Questionnaire

Redcliffe Dental
EST 1958

Please list all known allergies (eg. Penicillin, latex etc):

_____

_____

_____

Do you have, or have you ever experienced any of the following medical conditions?

- O Hepatitis A
- O Tuberculosis
- O Hepatitis B
- O Asthma
- O Hepatitis C
- O Diabetes
- O Contact with HIV/AIDS
- O Anaemia
- O Heart Complaint
- O Epilepsy
- O Cancer (specify below)
- O Other (specify below)
- O Rheumatic Fever
- O Kidney Disease
- O Cardiac Pacemaker
- O Thyroid Disease
- O Heart Valve Disorder
- O Nervous Condition
- O High Blood Pressure
- O Excessive Bleeding
- O Stroke
- O Joint Replacement
- O Reflux

Other Details _____

Women: Are you pregnant? Yes / No Due Date: Are you breastfeeding? Yes / No

Are you taking any medication for osteoporosis? _____

Do you normally require antibiotic cover before dental treatment?

Details: _____

Do you smoke? Yes / No / Social Frequency: _____

O Please tick here if you have private medical information that you wish to discuss with the dentist and not write on this form.

Medical Practitioner Details: _____
Name *Practice Address and Phone*

I acknowledge the information I have provided is true and correct:

Sign _____ Date _____

Office Use Only
Entered in D4W
Read by Practitioner