ashmore.
DENTISTRY

New Patient Dental & Medical Questionnaire

In order for this dental practice to provide the highest standard of care,
it is requested you fill in this form carefully and thoroughly.
All information on this form is, and will remain, strictly confidential under the Privacy Act 2014*

Patient Information

Surname: _____

Given Name: _____

Preferred Name: _____

Title: _____ Date of Birth: ____ / ____ / _____

Occupation: _____

Address: _____

Suburb: _____ Postcode: _____

Mobile: _____ ❑ *Preferred contact for appointment reminder*

Phone: _____ ❑ *(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

❑ Radio ❑ Google / Websites ❑ Walk in ❑ Social Media ❑ Family Member recommended ❑ Friend Recommended

❑ Other ➡ _____ Who can we thank for recommending you? _____

Medical History

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

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

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 ➡ Please provide more information:

_____

_____

_____

Do you have any allergies to antibiotics, medications, or other substances? ❑ No ❑ Yes ➡ _____

Have you <u>ever</u> taken any medication for any bone disorder? ❑ 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 ➡ _____

Do you have other medical conditions that you have not listed above? ❑ No ❑ Yes ➡ _____

Do you smoke cigarettes or take other recreational drugs? ❑ No ❑ Yes ➡ *How many per day?* _____

Do you drink alcohol? ❑ No ❑ Yes ➡ How many drinks per week? _____

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

Contacting General Medical Practitioner

*For the purposes of maintaining and collecting accurate information about our 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 Ashmore Dentistry 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 2014* and will be confidential.

Patient/parent/guardian signature : _____ Date: ____ / ____ / ____

GP name: _____ GP Practice: _____ GP contact phone: _____

Dental History

Are you attending for a specific problem? ❑ Yes ➡ Please provide more information: _____

❑ No _____

_____

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

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

Do you wish to be placed on a recall appointment list? ❑ 6 Monthly ❑ Yearly ❑ No

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

Have you had any problems with previous dental treatment? ❑ No ❑ Yes ➡ Please provide more information:

_____

_____

Are you satisfied with the appearance of your teeth? ❑ Yes ❑ No ➡ Please provide more information: _____

_____

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

Please tick the following you use for daily oral health? ❑ Non-fluoridated toothpaste ❑ Fluoridated toothpaste

❑ Electric toothbrush ❑ Toothbrush ❑ Interdental brushes ❑ Dental tape/floss

Do you drink fluoridated water? ('town' or 'council' water is fluoridated, bottle or tank water typically is not) ❑ Yes ❑ No

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

Consent For Service

- I, 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 payment is made on the day of service.
- I understand that Ashmore Dentistry 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 Ashmore Dentistry Privacy Policy, as per the Privacy act 2014, is available upon request.*