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Kallangur, QLD, 4503
Phone: (07) 3886 2428
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Prevent Dental Suite
Everyone Deserves a Beautiful Smile

Confidential Patient Details/Medical Questionnaire

Name: _____
Dr/Mr/Mrs/Miss/Ms ***First Name*** ***Surname***

Address: _____

Date of Birth: _____ **Dental Health Fund:** _____

Home Phone: _____ **Mobile:** _____

Work Phone: _____ **Occupation:** _____

Email: _____

Who can we thank for referring you to our practice: _____

Please provide answers and details regarding your medical history.

1. Are you receiving any medical treatment at this present time? **Yes/No**
Details: _____

2. Are you taking any medication at the moment? If yes, please list: **Yes/No**
Details: _____

3. Have you experienced allergies or unusual effects from any tablets, injections or anaesthetic? **Yes/No**
Details: _____

4. Have you ever had any of the following? ***If so please tick as appropriate:***

☐	Asthma	☐	Arthritis	☐	Epilepsy	☐	Rheumatic Fever
☐	High Blood Pressure	☐	Low Blood Pressure	☐	Thyroid Disease	☐	Tuberculosis
☐	Bronchitis/Chest Problems	☐	Chemo/Radiotherapy	☐	Severe Headaches	☐	Hepatitis: A B C
☐	Bleeding Disorder: Details -			☐	Diabetes: Details -		
☐	Heart Trouble: Details -			☐	Kidney Trouble: Details -		

5. Have you had any prosthetic surgery? (eg. Heart Valve or Hip Replacement) **Yes/No**
Details: _____

6. ***WOMEN*****, are you pregnant? If so, when is your due date:** _____ **Yes/No**

7. Have you ever had Hepatitis or been advised that you may be a carrier? **Yes/No**

8. Do you suspect that you are in a high risk category for HIV or AIDS? **Yes/No**

9. Do you require antibiotic cover before dental treatment? **Yes/No**

Details of person to contact in an emergency:
Name: _____ **Phone Number:** _____
Name & Location of your Physician/GP: _____ **Phone (if known)** _____

PLEASE TURN OVER PAGE

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Dental Questionnaire

1. **Name and location of last dentist?** _____
2. **Approximate date of last dental visit?** _____
3. **Do you have *dental pain* or a *dental problem* at present?** _____
4. **Do you become *anxious* or *uncomfortable* when you are having dental treatment?** **Yes/No**
5. **Do you brush and floss daily?** **Yes/No**
6. **Is there anything with your teeth that you are unhappy about?** _____ **Yes/No**
7. **Do you grind or clench your teeth?** **Yes/No**
8. **Do you experience any sensitivity with hot/cold?** **Yes/No**
9. **Is there anything else you would like the dentist to know?** _____ **Yes/No**
10. **Are you a smoker?** **Yes/No**

Consent for Treatment

1. **I hereby understand that the failure to complete the medical information may place others and myself at risk.**
2. **I understand that this patient detail/medical history questionnaire is treated with complete confidentially.**
3. **I understand that if I fail to give 48 hours notice to cancel my appointment, that a fee may be charged.**
4. **I agree to be responsible for payment of all services rendered on my behalf, and on the behalf of my dependents understand that this payment is due at the time of service unless other arrangements have been made.**

Patient (Responsible Party) Signature: _____ **Date:** _____