

New Patient Questionnaire – Page 1 of 2

For your convenience, please complete this questionnaire prior to arriving for your first appointment.

Please note that any information provided will remain STRICTLY CONFIDENTIAL

Patient Information

Surname*: _____ Title: _____

Given Name(s)*: _____ Date of Birth: _____

Phone number (home): _____ Phone number (work): _____

Mobile number: _____ E-mail: _____

Please notify me of appointments by (please circle): **MAIL** **PHONE** **EMAIL** **SMS**

Home Address: _____

Suburb: _____ Post Code: _____

Company name & address: _____

Suburb: _____ Post Code: _____

Occupation: _____

Do you belong to a Health Fund? If so, which one: _____

* If the patient is a minor please note below the name of the parent or guardian completing this form.

Surname: _____ Title: _____

Given Name(s): _____

Referral Information

How did you hear about our practice (Please circle):

www.dentist.com.au Yellow Pages on the Internet Yellow Pages Phone Book Yellow Pages Directory Assistance

Newspaper Advertising Advertising in: _____ Other: _____

Friend/Family member – if so, whom may we thank for referring you to our practice? _____

Is this person a patient of this practice? (please circle Yes or No) YES NO

Medical History

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

Anaemia	Diabetes	Excessive Bleeding	Kidney Disease	Rheumatic Fever
Artificial Joints	Dizziness	Fainting	Liver Disease	Sinus Problems
Asthma	Dry Eyes	Glaucoma	Pacemaker	Stroke
Blood Disease	Dry Mouth	Heart Murmur	Psychological Disorders	Tinnitus (ringing in your ears)
Cancer	Ear infection	Hepatitis A, B or C	Radiation Therapy	Tuberculosis
Depression	Epilepsy	Jaundice	Respiratory problems	Tumours

Name of your Doctor: _____ Phone number: _____

Female patients: Are you pregnant? _____ How many months? _____

Have you been pregnant before (how many times)? _____

Did you notice any changes in your mouth during or following your pregnancy? _____

Have you had any other serious illness or surgical procedures? If so, please explain: _____

Are you taking any medicines or tablets regularly? YES NO If yes, please explain: _____

Are you allergic to Latex, penicillin or other drugs? YES NO If yes, please explain: _____

Are you allergic to any foods (peanuts, milk, etc) YES NO If yes, please explain: _____

Is your Blood Pressure low or high? NO HIGH LOW Do you smoke? YES NO

Do you have HIV, AIDS or HEP C YES NO Are you in a high-risk category? YES NO

Next of Kin (in case of emergency):

Name: _____ Phone number: _____

Address: _____

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Dental History

Have you suffered recently from the following dental problems: (please circle yes or no)

Sensitivity to hot or cold:	YES NO	Food trapping between your teeth:	YES NO
Clicking or pain in the joints of the jaw:	YES NO	Staining of your teeth or fillings:	YES NO
Roughness of your teeth or fillings:	YES NO	Bleeding gums:	YES NO
Bad taste or bad breath:	YES NO	Sensitivity to eating:	YES NO
Mouth ulcers:	YES NO	Jaw clenching or grinding:	YES NO
Head/Neck ache:	YES NO	Consistent dry mouth	YES NO

In an average day, how much tea, coffee, soft drinks, sports drinks and/or flavoured drinks do you consume? _____

Have you ever experienced any adverse reactions with the use of local anaesthesia? _____

Are you happy with: (please circle yes or no)

Appearance of your teeth:	YES NO	Existing crowns, bridges or dentures:	YES NO
Ability to eat:	YES NO	Your toothbrushing technique:	YES NO
Smile:	YES NO	Your flossing technique:	YES NO

Do you: (please circle yes or no)

Snore	YES NO	Play contact sports (rugby, football, etc)	YES NO
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What is the purpose of your visit? _____

How long since your last dental visit? _____

Would you describe yourself as a relaxed dental patient? YES NO

Why did you decide to leave your previous dental practice? _____

Cosmetic Evaluation

Would you like to have whiter teeth?	YES NO
Are you happy with your smile?	YES NO
When you smile in the mirror are you conscious of any defects to your teeth or gums?	YES NO
Do you show too much gum when you smile or laugh?	YES NO
Do you feel that your teeth are too long or too short?	YES NO
Do you feel that your teeth are too wide or too narrow?	YES NO
Are there spaces between any of your teeth that concern you?	YES NO
Do you have teeth that are crooked, uneven or out of line?	YES NO
Do you have any gray, black, or silver (mercury) fillings in your teeth that you are unhappy with?	YES NO

Consent for Services

- This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated and I will assume responsibility for the fees associated with those procedures.
- I understand that it is the policy of the practice for all treatments to be paid for at the time of the appointment or in advance. Any arrangements for delayed payment are to be made prior to treatment commencing.
- I shall pay any legal costs, including solicitor and own costs, tracing costs and any collection commission incurred by the practice as a result of my failure to pay any amounts due.
- I understand that the practice utilises the services of The Credit Reference Association of Australia Limited (CRAA). I agree to the practice obtaining from the CRAA a credit report containing personal credit information about me in relation to consumer credit provided by GDG (Section 18K(1)(b), Privacy Act 1998). I have been advised that it is the policy of the practice to list any defaulting accounts with the CRAA.

Signature of patient (parent or guardian): _____ DATE _____