BALLARAT
essential dental

11 Drumond Street South
Ballarat, VIC 3350
tel : (03) 53311959
fax : (03) 53333887
info@essentialdental.com.au
www.essentialdental.com.au

New patient questionnaire form

WE RESPECT YOUR PRIVACY

In order to provide you with the highest standard of dental care, this practice is required to collect personal information from you. This information covers basic details such as your name, address and telephone number, but it is also necessary for us to obtain from you details regarding your general health and past medical or surgical treatments and procedures. Without this general health profile, the treating Dentist or Hygienist is unable to plan your care properly.

Naturally, some of this information is of a personal nature, some of it may be regarded as 'sensitive' and not the sort of information you would wish to be unnecessarily disclosed to others. We value the need to safeguard this information and in accordance with the principles laid down in privacy legislation and the guidelines issued by the Australian Dental Association, we would like to assure you that:

- This information will only be used by the treating Dentist or Hygienist in order to deliver your care to the highest standards
- It will not be disclosed to those not associated with your treatment without your expressed consent
- You may seek access to the information held about you and we provide this access without undue delay. This access might be by inspection of your dental records at the time of your appointment or by special access or copying of information at other times
- There will be no charge made for requesting this information but there may be fees levied just to cover the costs associated with the processing of this request or the copying of information.
- We will take reasonable steps to ensure at all times that the details we keep about you are accurate, complete and up-to-date
- We will take all reasonable steps to protect this information from misuse or loss and from unauthorised access, modification or disclosure
- Our staff are trained to respect these principles at all times

If you have any questions regarding the information we collect from you and hold in your dental records, please do not hesitate to ask us. We are acting in your interests at all times.

Prof Dr Fr Mr Mrs Ms Miss Master

Full Name ____

Address ____

Home phone _________________________________

Work phone _________________________________

Mobile phone ________________________________

Email ____

Date of birth _________________________________

Occupation __________________________________

Employer ____________________________________

Health insurance _________________________________

Contact person in case of emergency ____

Who referred you to our office? ____

Person responsible for dental investment ____

When was your last dental visit? ____

Why did you leave your last dentist? ____

What has been your concern with previous dental visits? ______________________________

What is your main dental concern today? ____

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Are your teeth sensitive to:

- O Heat
- O Sweet
- O Cold
- O Biting pressure

Does food catch between your teeth? ____

Do your gums bleed when brushing or flossing? ____

Do you notice an unpleasant taste or odour in your mouth? ______________________________

Have you had any complications during or following dental treatment?_________________________

____

Have you had prolonged bleeding after tooth removal or dental surgery?_______________________

Is there anything you would like to change about your teeth or their appearance?________________

____

____

Do you grind your teeth or clench your jaws? _____________________________

Have your jaw muscles ever been sore? Yes or No

Please describe how you feel about dental treatment by putting an X on this line

Pleasant _______________________ 0 _______________________ Terrible

Are you being treated for a medical condition? ____

____

Who is your doctor? ____

Are you taking any medications or supplements at present, both prescribed or over the counter?

(Please list) ____

____

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

- O Steroid therapy
- O Rheumatic fever
- O Epilepsy
- O Asthma
- O Diabetes
- O Heart valve disorder
- O Stroke
- O Radiation or chemotherapy
- O Kidney disease
- O Heart complaint or heart surgery
- O Eating disorder
- O Stomach or digestive condition (reflux)
- O Leukaemia, cancer
- O Nervous condition
- O Tuberculosis
- O Thyroid disease
- O Heart murmur
- O High or low blood pressure
- O Transported organ or bone marrow
- O Cardiac pacemaker
- O Excess bleeding
- O Hepatitis or liver disease
- O Contact with HIV/AIDS virus
- O Anaemia or blood disorder
- O Prosthetic implant eg.
- O Prosthetic hip or knee
- O Bronchitis, emphysema or other lung disease
- O Other ________________________

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Please list all known allergies ____

____

____

____

Do you smoke? ________________________________

For females, are you pregnant or undergoing fertility treatment?______________________________

Your signature: ____________________________ Date: ____________________