

Welcome to Dental Centre Buderim

To help us give you the best possible treatment, please answer the following *confidential* questions to help us get to know you better and understand your dental needs.

Title: Dr / Mr / Mrs / Ms / Miss / Master (please circle)

Date of Birth: ____/____/____

Surname: _____

Phone: _____

First Name: _____

Mobile: _____

Address: _____

Email: _____

Suburb: _____

Appointment Reminder SMS / Email / No thanks

Post code: _____ **Occupation:** _____

☐ Opt out of communications (e.g. email newsletters)

Are you covered for Dental by a health fund? ☐ Yes, fund name: _____ ☐ No
Membership # _____ Your number on card: _____

Are you currently receiving medical treatment? ☐ Yes, details: _____ ☐ No

Are you currently taking any medications? ☐ Yes, details: _____ ☐ No

Have you ever suffered a serious illness? ☐ Yes, details: _____ ☐ No

Do you have **any** allergies? (foods/medicines/other) ☐ Yes, details: _____ ☐ No

Have you had any dental treatment in the past that you would like us to know about? ☐ Yes, details: _____ ☐ No

Do you have any abnormal reactions to local or general anesthesia? ☐ Yes, details: _____ ☐ No

Have you taken aspirin in the past two days? ☐ Yes ☐ No

Have you taken steroids in the last two years? ☐ Yes ☐ No

Are you on any medication/injections for bone weakness? (ie osteoporosis) ☐ Yes ☐ No

Are you pregnant or breastfeeding? (females only) ☐ Yes ☐ No

Do you normally require antibiotic cover before dental treatment? ☐ Yes ☐ No

Please tick if you have or have had any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart attack, disease, surgery, murmur, disorder or complaint | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Transplants | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Kidney/liver disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis (A / B / C) |
| <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Bruise/bleed excessively | <input type="checkbox"/> Bone disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Blood disease | <input type="checkbox"/> Rheumatic fever |
| | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Thyroid disease |

How are you feeling about your visit today? (please circle)

At Ease 2 3 4 5 6 7 8 9 Very Anxious

How did you hear about us? (please circle)

Google online search / Yellow Pages / Facebook / Signage / Newsletter / Qld Health / Health fund / Friend or word of mouth / Other Promotion _____

Please Note:

- ✓ Payment is required at the end of all visits, as we do not operate accounts.
- ✓ The information you have provided is handled in accordance with the Privacy Policy established by the Australian Dental Association (ADA).
- ✓ If you must cancel your appointment, we require 24 hours notice or a cancellation fee may apply.
- ✓ You are giving consent to be examined and/or treated by our dental staff.

Patient Signature: _____

Date: ____/____/____

Parent/Guardian Name: _____

(Parent/Guardian please sign and write full name if the patient is a child under 18 years of age)

Thank you!