

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 (<i>please circle</i>)		Date of Birth: ____/____/____
Surname: _____		Phone: _____
First name: _____		Mobile: _____
Address: _____		Email: _____
Postcode: _____ Occupation: _____		Appointment Reminder SMS / Email / Phone / None <input type="checkbox"/> <i>Opt out of communications (eg. Email, newsletters)</i>

Are you covered by a Dental health fund?	<input type="checkbox"/> Yes, Member Number: _____	<input type="checkbox"/> No
Are you currently receiving medical treatment?	<input type="checkbox"/> Yes, Details: _____	<input type="checkbox"/> No
Are you currently taking any medications?	<input type="checkbox"/> Yes, Details: _____	<input type="checkbox"/> No
Have you suffered a serious illness?	<input type="checkbox"/> Yes, Details: _____	<input type="checkbox"/> No
Do you have any allergies?	<input type="checkbox"/> Yes, Details: _____	<input type="checkbox"/> No
Have you had any dental treatment in the past that you would like us to know about?	<input type="checkbox"/> Yes, Details: _____	<input type="checkbox"/> No
Do you have abnormal reactions to local or general anaesthesia?	<input type="checkbox"/> Yes, Details: _____	<input type="checkbox"/> No
Have you taken Aspirin in the past 2 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you taken Steroids in the last 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you on any medication/receiving injections for bone weakness? (i.e. Osteoporosis)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Females - are you pregnant or breast feeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you normally require antibiotic cover before dental treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

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|--|---|--|
| <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 / Low Blood Pressure (<i>circle</i>) | <input type="checkbox"/> Kidney / Liver Disease (<i>circle</i>) | <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"/> Bruising / Bleed Excessively | <input type="checkbox"/> Bone Disease | <input type="checkbox"/> Diabetes (Type:) |
| <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	Anxious
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How did you hear about us? (*Please circle*)

Google online search / Yellow Pages / Facebook / Signage / Newsletter / QLD Health / Health Fund Company / Family/Friend/Word of Mouth / Other _____

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 cancel your appointment, we will require no less than 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:** ____/____/____
Guardian name: _____ (*Patients under 18y*)

Thank you!