THE DENTAL TOUCH

New Patient Questionnaire

The information provided here is to enable us to provide you with the best possible dental care.
Please also note that all information given remains confidential.

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other: _____

Patient's Surname: _____ First Name/s: _____

Street Address: _____

Suburb: _____ Post Code: _____

Phone: Home: _____ Work: _____ Mobile: _____

Email address: _____

Date of Birth: ____/____/_____ Occupation: _____

How did you find out about our practice? _____

Name of person responsible for account if different from above: _____

Street Address: _____

Suburb: _____ Post Code: _____

Phone: Home: _____ Work: _____ Mobile: _____

Are you covered for dental services under private health cover? ☐ Yes ☐ No

If yes, please name the health fund: _____

* Please note that if you have Private Health cover, some costs of treatment may be reimbursable to you from your fund. We require payment in full on the day of treatment regardless when your Health Fund will reimburse you.

Family Doctor details: Dr: _____

Address: _____

Phone: _____

Please tick the applicable boxes below if you have or suffer from any of the following?

- ☐ AIDS / HIV
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Birth Defects
- ☐ Blood Disease
- ☐ Bruised Easily
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness / Fainting
- ☐ Emotional Problems
- ☐ Endocrine Problems
- ☐ Epilepsy
- ☐ Head or Face Injury
- ☐ Hearing Disorders
- ☐ Heart Trouble: _____
- ☐ Heart Murmur
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ High Blood Pressure
- ☐ Swollen or Painful Joints
- ☐ Intestinal Disorder
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Low Blood Pressure
- ☐ Nervous Disorders
- ☐ Numbness of Arms/Hands
- ☐ Osteoporosis
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Substance Abuse
- ☐ Other: _____ _____

Are you taking any Medication? ☐ Yes ☐ No

Please list: _____

Do you have any Allergies? ☐ Yes ☐ No

Please specify: _____

1. Are you Pregnant? ..... ☐ Yes ☐ No

   If yes, at how many months: _____

2. Have you had your tonsils or adenoids removed? ……..... ☐ Yes ☐ No

3. Do you have unreplaced missing teeth? ……..... ☐ Yes ☐ No

If yes, would you like advice on tooth replacement? ……..... ☐ Yes ☐ No

4. Do your gums bleed when brushing your teeth? ……..... ☐ Yes ☐ No ☐ Sometimes

5. Are you conscious of a bad taste or odour at times? ……..... ☐ Yes ☐ No ☐ Sometimes

6. Are any of your teeth sensitive to any of the following? ……..... ☐ Hot ☐ Cold ☐ Sweet

7. Is any part of your mouth painful while chewing? ……..... ☐ Yes ☐ No ☐ Sometimes

8. Are you happy with the appearance of your teeth? ……..... ☐ Yes ☐ No

   If not, would you like advice on how to enhance your smile? ☐ Yes ☐ No

9. Are you comfortable during dental visits? ……..... ☐ Yes ☐ No

   If not, what makes you feel uncomfortable? _____

10. Do you snore? ……..... ☐ Yes ☐ No

    If yes, would you like advice on how to treat your snoring? ☐ Yes ☐ No

11. Have you ever been diagnosed or treated for snoring or obstructive sleep apnoea (OSA) ?..... ☐ Yes ☐ No

12. Have you ever had Orthodontic treatment? ……..... ☐ Yes ☐ No

13. Do you clench or grind your teeth at night? ……..... ☐ Yes ☐ No ☐ Sometimes

14. Do suffer from a clicking jaw or have trouble opening your jaw?..... ☐ Yes ☐ No

15. Do you suffer from regular headaches or migraines? ……..... ☐ Yes ☐ No

    If yes and you take painkillers for this, please list: _____

24 hours notice for all appointment cancellations is required or a cancellation fee may be charged. I acknowledge and agree to settle all payments for services at the time of consultation.

Signed _____ Date _____