

Welcome to Dental Centre Peregian Springs

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: _____

Contact Number: _____

First Name: _____ **Preferred Name:** _____

Email: _____

Address: _____

Medicare Card Number: _____

Appointment Reminder: Phone / SMS / Email / No thanks

Suburb: _____ **Postcode:** _____

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

Occupation: _____

GP Details: _____

Are you covered for Dental by a health fund?
Membership #

☐ Yes, fund name:
Your number on card:

☐ No

Are you currently receiving medical treatment?

☐ Yes, details:

☐ No

Are you currently taking **any** medications?

☐ Yes, details:

☐ No

Are you on any medication/injections for **bone weakness/osteoporosis?**
(if yes please circle) Fosamax , Actonel , Aclasta , Zometa , Bonvia , Prolia (Denosumab)

☐ Yes

☐ No

☐ Other

Have you ever suffered a serious illness?

☐ Yes, details:

☐ No

Do you have **any** allergies? (foods/medicines/latex)

☐ 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 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:

- ☐ Heart attack, disease, surgery, murmur, disorder or complaint
- ☐ Cardiac pacemaker
- ☐ High or low blood pressure
- ☐ Angina
- ☐ Respiratory disease
- ☐ Bruise/bleed excessively
- ☐ Artificial joints

- ☐ Epilepsy
- ☐ Transplants
- ☐ Kidney/liver disease
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Bone disease
- ☐ Blood disease
- ☐ Lung disease

- ☐ Radiation Therapy
- ☐ Cancer
- ☐ Asthma
- ☐ Hepatitis (A / B / C)
- ☐ HIV or AIDS
- ☐ Diabetes
- ☐ Rheumatic fever
- ☐ Thyroid disease

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!