STRATHPINE DENTAL CENTRE

Welcome to Strathpine Dental Centre

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)*

DOB: ____/____/____

Surname: _____

Preferred Name: _____

First Name: _____

Phone: _____

Address: _____

Mobile: _____

Suburb: _____ **Post code:** _____

Occupation: _____

Email:_____ **Health Fund?** ☐ **Yes, *fund name*** _____ ☐ **No**

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?	☐ Yes, *details*:	☐ No
Have you had any abnormal reactions to anesthetics?	☐ 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 a smoker?	☐ Yes	☐ No
Are you pregnant or breastfeeding? *(females only)*	☐ Yes	☐ No
Does your cardiologist or doctor require you to have Antibiotic Cover for dental treatment?	☐ Yes	☐ No
How long since your last dental examination?		

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

Yes	*No*		*Yes*	*No*		*Yes*	*No*	
☐	☐	Heart Condition	☐	☐	Epilepsy	☐	☐	HIV
*Please specify*_____			☐	☐	Tuberculosis	☐	☐	Cancer
☐	☐	Cardiac pacemaker	☐	☐	Artificial joints	☐	☐	Radiation therapy
☐	☐	High or low blood pressure	*Please specify*_____			☐	☐	Rheumatic fever
☐	☐	Stroke	☐	☐	Transplants	☐	☐	Thyroid disease
☐	☐	Asthma or Respiratory disease	*Please specify*_____			☐	☐	Diabetes
☐	☐	Bleed/Bruise excessively	☐	☐	Kidney/Liver disease	☐	☐	Other
☐	☐	Blood disorder	☐	☐	Hepatitis	*Please specify*_____		
☐	☐	Osteoporosis – *If yes, list any medications you are taking, or have taken in the past*						

Actonel/Fosamax/Other (*Please specify*) _____

Prolia 6 monthly Injections – YES / NO

How did you hear about us? *(Please circle)*

Facebook / Google online search / Smile.com.au / Front signage / Newsletter / Qld Health / Health fund /

Friend or word of mouth / Yellow Pages / Other Promotion _____

Please Note:

- ✓ The information you have provided is handled in accordance with the Privacy Policy established by the Australian Dental Association (ADA).
- ✓ Payment is required at the end of all visits, as we do not operate accounts.
- ✓ 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 please sign if the patient is a child under 18 years of age)

Updated Patient Signature: _____ **Update**: ____/_____/_____

Thank you!