North Road Dental Clinic

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CONFIDENTIAL PATIENT QUESTIONNAIRE

First Names: Dr / Mr / Mrs /Miss / Ms _____, _____ **Date of birth**: ____/____/_____

Surname: _____ **Any other Language**: _____

Home Address: _____ **Post Code**: _____

Home Phone: _____ **Work** Phone: _____

Mobile Phone: _____ **E-mail**:_____

Occupation: _____

Medicare / Veterans Affair card number: _____

Details of person to contact in an emergency: Name: _____ Phone: _____

Medical Doctors Name: _____ Phone: _____ Address: _____

MEDICAL HISTORY

1. Are you currently taking any **medicine** tablets, capsules or drugs? Yes/ No

   Names: _____

   _____

2. Do you have any **allergies** or unusual effects from any **medications, injections, latex** ? Yes/No

   _____

3. Have you ever had any of the following? If so, please tick/indicate as appropriate:

□	Rheumatic Fever	□	Excessive Bleeding / Bruising
□	Heart Trouble / **Valve surgery**	□	Hep. A,B,C / HIV
□	High Blood Pressure	□	Epilepsy / Fits
□	Diabetes	□	Thyroid problems
□	Stroke	□	Kidney Trouble
□	Asthma / Tuberculosis (TB)	□	Depression / Anxiety
□	Arthritis / Osteoporosis	□	Hip / Knee Replacement surgery
□	Stomach Trouble / Reflux	□	Alcohol consumption Daily/Weekly/Monthly
□	Cancer If so, where _____	□	Smoker _____cigarettes/day; _____ years

4. Are you pregnant? Yes/No If so, details: _____
5. Do you have any dental **Private Health Insurance**? Yes/No Fund: _____

   Membership No.: _____ Reference No.:_____
6. Reason/concern for your dental visit today:

   _____

How Did You Hear About Us? _____

If you are under 18 years of age, please state Parent/Guardian's name: _____

Signed by Patient/Parent/Guardian: _____ Date: _____/_____/_____

Signed by Dentist: Dr._____, _____ Date: _____/_____/_____