Kogarah Dental Care
General & Family Dentist

DENTAL QUESTIONNAIRE

Dear Patient, Welcome to our practice!
This information is confidential. You are not obligated to answer all questions. It will assist us greatly in our efforts to provide the best dental treatment for you.

Mr., Mrs., Miss, Ms, Dr., Prof., Master
Surname……………………………………. Given names…………………………………………

Date of Birth………………………………….

Address………………………………………………………………………………………………

Phone Home…………………...…Work………………………..Mobile………………………

Email Address…………………………………………………………………………….....

Occupation………………………………………………………………………………..

Health fund (dental) Yes/No   Name of Fund…………………………………………………

Is somebody else responsible for payment of your account? Who?……………………………

Recommended to our practice by………………………………………………………………

Main reasons for today's visit?………………………………………………………………

…………………………………………………………………………………………………

Are you happy with the appearance of your teeth?………………………………………………

Would you like to discuss cosmetic options?...

PAYMENT OPTIONS

Payment is requested on the day of treatment. We accept most credit cards, debit cards, personal cheque and cash. We can claim most health funds directly for you if you have your fund card. We have no relationship with your fund and any disputes must be settled directly with your fund.

Note, appointment times are reserved for you. We will do our best to see you on time.

Failure to attend your appointment without 24 hour notice may incur a fee

MEDICAL HISTORY   Do you, or have you ever, suffered from any of the following?

1. Heart / vascular disorder   No/Yes

2. Blood disease / bleeder   No/Yes

3. High blood pressure   No/Yes

4. Reactions to local anesthetics   No/Yes

5. Headaches, neck or facial pain   No/Yes

6. Rheumatic fever   No/Yes

7. Radiation therapy   No/Yes

8. Allergy penicillin   No/Yes

9. Epilepsy   No/Yes

10. Artificial joint, limb, valve etc.   No/Yes

Comments (1-10) …………………………………………………………………………………

Are you pregnant or
breastfeeding?…………………………………………………………………………………….

List all
allergies…………………………………………………………………………………………

MEDICATIONS Please list all: Asprin, Antidepressants, Biphosphonates (eg Fosimax), Warfarin, etc.

…………………………………………………………………………………………………….

Other medical……………………………………………………………………………………..

Aids, Hepatitis B and Hepatitis C viruses – could you be a high-risk patient?   No/Yes

Is there anything you wish to discuss with the dentist in private?   No/Yes

Any changes to your medical situation should be reported immediately.

Please Sign………………………………………………….*Date*…………………………