confidential**new** **patient**questionaire

Surname . . . . . First Name(s) . . . . . Dr/Mr/Master/Mrs/Miss/Ms

Address . . . . . .

Date of Birth . . . . . Occupation . . . . . .

Mobile . . . . . Other Phone. . . . . .

Email Address . . . . . .

Emerald Dental Group, gives courtesy SMS text 48 hours prior to all appointments

Would you prefer your appointment reminder via (please tick one or more) ◯ SMS ◯ PHONE ◯ EMAIL

Details of person to contact in an emergency

Name . . . . . Phone . . . . . .

Medical History

Medical Doctor . . . . . Phone (if known) . . . . . .

1. Are you receiving any medical treatment at present? ◯ YES ◯ NO

Details . . . . . .

2. Have you been a patient in hospital during the past 12 months? ◯ YES ◯ NO

Reason . . . . . .

3. Are you at present taking any pain relief, drugs or medications? ◯ YES ◯ NO

If so, please note details . . . . . .

4. Have you experienced any allergies from any medications/anaesthetic/antibiotics? ◯ YES ◯ NO

Details . . . . . .

5. Have you ever had any of the following?

- ◯ Rheumatic Fever
- ◯ Heart Trouble
- ◯ High Cholesterol
- ◯ Asthma
- ◯ Sinus Trouble
- ◯ Epilepsy
- ◯ Diabetes
- ◯ Severe Headaches
- ◯ Overactive Thyroid
- ◯ Underactive Thyroid
- ◯ Gastric Problems
- ◯ Bronchitis or Chest Problems
- ◯ High Blood Pressure
- ◯ Low Blood Pressure
- ◯ Circulatory Problems
- ◯ Excessive Bleeding
- ◯ Anaemia or other Blood Disorders
- ◯ Hepatitis/Aids/HIV
- ◯ Artificial Joints
- ◯ Cold Sores
- ◯ Liver or Kidney Problems
- ◯ Anxiety/Depression (please circle)
- ◯ Allergies to Latex
- ◯ Cancer/Radiation Treatment

If necessary please specify . . . . . .

6. Have you had any prosthetic surgery? (eg Heart Valve or Hip Replacement) ◯ YES ◯ NO

Date/Details (if known) . . . . . .Do you require Antibiotic Cover? ◯ YES ◯ NO

7. Do you have any social habits?

- ◯ Smoking – if so how many per day . . . . . .
- ◯ Soft Drinks – how many cans per day . . . . . .
- ◯ Energy/Sports Drinks – if so how many per day . . . . . .
- ◯ Children Thumb/Digit Sucking
- ◯ Mouth Breathing
- ◯ Difficulty Swallowing/Dry Mouth
- ◯ Grinding
- ◯ Snoring

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8. Do you have a Pace Maker? ◯ YES ◯ NO

9. Ladies, Are you pregnant? ◯ YES ◯ NO

If so how many weeks. . . . . .

10. Have you ever had biphosphonate drugs for cancer or osteoporosis? ◯ YES ◯ NO

11. Any Other Conditions

. . . . . .

Dental History

1. Name of last dentist . . . . . .

Dental Visit Frequecy ◯ 2x/year ◯ 1x/year ◯ Emergency Only

2. When was your last set of dental x-rays taken? . . . . . .

3. When was your last oral health cleaning done? . . . . . .

4. When was your last oral cancer screening done? . . . . . .

5. Have you ever had any of the following?

- ◯ Jaw "click" or hurt
- ◯ Grind your teeth
- ◯ Ever had Orthodontic Treatment
- ◯ Wear a Dental Night Guard
- ◯ Periodontal (Gum) Treatment
- ◯ Bite adjustments
- ◯ Occassional bad breath
- ◯ Bleeding gums when cleaning
- ◯ Sensitivity with hot/cold
- ◯ Difficulty Flossing
- ◯ Food impaction area's
- ◯ Bite your lips or cheeks

6. On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
Where would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10

7. What best describes your current situation:

- ◯ I want a thorough examination and I'm aware that work needs to be done
- ◯ I would like a thorough examination and treatment plan consultation
- ◯ I'm having pain and need immediate assistance
- ◯ I'm in great shape and I just need my teeth cleaned as soon as possible.

8. If appropriate, I avoided dental care in the past due to:

- ◯ Fear of . . . . . .
- ◯ Time Commitments
- ◯ No Preceived Need (over-treatment?)
- ◯ Financial Commitments
- ◯ Trust Factor

9. If appropriate, I am changing dentists because:

- ◯ Recently moved to this area from . . . . . .
- ◯ Dr/Staff personality/communication problem
- ◯ To find a dental team who understands my needs
- ◯ Different dentist at each visit
- ◯ Inadequate Care
- ◯ Health fund restricted dental clinic
- ◯ Fee Concerns

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10. How did you first hear about us? (please tick the appropriate)

- Convenient location/Passing by/Walk in (saw practice sign from the road)
- Google.com
- EmeraldDentalGroup website
- Family member already comes here (who?) . . . . . .
- Referred by a friend (who?) . . . . . .
- CQ News
- Blackwater Herald
- Google Plus
- Yellow pages
- Local Directories
- Instagram
- Facebook
- Emerald Eagles Soccer Club
- Harvest Life Church

11. Are you interested in exploring any of these options?

- Ways to reduce or eliminate periodontal disease/surgery
- Invisalign - invisible orthodontic aligners
- At home whitening Deep whitening
- The best dental home care system
- Information on helping snoring or sleep apnoea in your home
- Sedation dentistry options
- Smile makeovers - smile analysis and design
- Why dental infections cause heart and other diseases
- Help with jaw alignment problems and jaw pain
- Rehabilitation of heavily worn teeth
- Interceptive Orthodontics/Traditional Braces (Dr Christy) Please circle

12. Do you have any questions or concerns you would like to discuss with your Dentist? YES NO

. . . . . .

. . . . . .

Your health information will treated with the upmost confidentiality. Disclosure will not be made to any person not involved directly with this practice, without your prior written consent. If you have any queries or concerns about the handling of your health information, please raise these concerns with our practice staff.

Appointment Policy

If you need to change or cancel your appointment with us for any reason, please kindly give at least 48 hours notice if possible, otherwise a cancellation fee may be incurred.
ACCOUNTS MUST BE PAID IN FULL ON THE DAY OF TREATMENT

Patient/Parent/Guardian . . . . . Date . . . . . .

Authorization

I certifty that I have read and answered the above questions to the best of my knowledge. I understand that my failure to disclose all relative health information may be dangerous to my health and treatment outcomes. I agree that any necessary examinations and records be taken for an accurate diagnosis of my current dental situation.

Patient/Parent/Guardian . . . . . Date . . . . . .