

**confidentialnew  
patientquestionnaire**

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?**

<input type="radio"/> Rheumatic Fever	<input type="radio"/> Overactive Thyroid	<input type="radio"/> Anaemia or other Blood Disorders
<input type="radio"/> Heart Trouble	<input type="radio"/> Underactive Thyroid	<input type="radio"/> Hepatitis/Aids/HIV
<input type="radio"/> High Cholesterol	<input type="radio"/> Gastric Problems	<input type="radio"/> Artificial Joints
<input type="radio"/> Asthma	<input type="radio"/> Bronchitis or Chest Problems	<input type="radio"/> Cold Sores
<input type="radio"/> Sinus Trouble	<input type="radio"/> High Blood Pressure	<input type="radio"/> Liver or Kidney Problems
<input type="radio"/> Epilepsy	<input type="radio"/> Low Blood Pressure	<input type="radio"/> Anxiety/Depression (please circle)
<input type="radio"/> Diabetes	<input type="radio"/> Circulatory Problems	<input type="radio"/> Allergies to Latex
<input type="radio"/> Severe Headaches	<input type="radio"/> Excessive Bleeding	<input type="radio"/> 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?**

<input type="radio"/> Smoking – if so how many per day .....	<input type="radio"/> Mouth Breathing
<input type="radio"/> Soft Drinks – how many cans per day .....	<input type="radio"/> Difficulty Swallowing/Dry Mouth
<input type="radio"/> Energy/Sports Drinks – if so how many per day .....	<input type="radio"/> Grinding
<input type="radio"/> Children Thumb/Digit Sucking	<input type="radio"/> Snoring

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 Frequency  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?
- |  |   |   |
|--|---|---|
| <input type="radio"/> Jaw "click" or hurt            | <input type="radio"/> Periodontal (Gum) Treatment | <input type="radio"/> Sensitivity with hot/cold |
| <input type="radio"/> Grind your teeth               | <input type="radio"/> Bite adjustments            | <input type="radio"/> Difficulty Flossing       |
| <input type="radio"/> Ever had Orthodontic Treatment | <input type="radio"/> Occasional bad breath       | <input type="radio"/> Food impaction area's     |
| <input type="radio"/> Wear a Dental Night Guard      | <input type="radio"/> Bleeding gums when cleaning | <input type="radio"/> 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 Perceived Need (over-treatment?)
  - Financial Commitments
  - Trust Factor
9. If appropriate, I am changing dentists because:
- |  |  |
|--|--|
| <input type="radio"/> Recently moved to this area from .....         | <input type="radio"/> Inadequate Care                      |
| <input type="radio"/> Dr/Staff personality/communication problem     | <input type="radio"/> Health fund restricted dental clinic |
| <input type="radio"/> To find a dental team who understands my needs | <input type="radio"/> Fee Concerns                         |
| <input type="radio"/> Different dentist at each visit                |  |

**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

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Your health information will be 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 certify 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 .....