APPLECROSS
DENTAL CARE

PATIENT PERSONAL & MEDICAL QUESTIONNAIRE

Please take time to answer these questions as accurately as possible. It will assist us greatly in our effort to provide the best possible dental treatment for you. All information will be treated with complete professional confidentiality. Thank you.

TITLE: _____ FIRST NAME: _____ SURNAME: _____

PREFERRED NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

_____ POST CODE: _____

HOME PHONE: _____ WORK PHONE: _____

MOBILE: _____ EMAIL: _____

Preferred daytime contact for confirmation of appointments:

SMS ◯ MOBILE ◯ HOME ◯ WORK ◯ EMAIL ◯

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT: _____ PHONE: _____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT: _____

NAME OF PRIVATE HEALTH FUND: _____

WHOM DO WE THANK FOR RECOMMENDING YOU TO OUR PRACTICE: _____

HOW LONG HAS IT BEEN SINCE YOUR LAST DENTAL CHECK: _____

Office use only:

UPDATED: _____ CHANGES ◯ NONE ◯	UPDATED: _____ CHANGES ◯ NONE ◯
UPDATED: _____ CHANGES ◯ NONE ◯	UPDATED: _____ CHANGES ◯ NONE ◯
UPDATED: _____ CHANGES ◯ NONE ◯	UPDATED: _____ CHANGES ◯ NONE ◯
UPDATED: _____ CHANGES ◯ NONE ◯	UPDATED: _____ CHANGES ◯ NONE ◯

PATIENT CARD #: _____ PROVIDER: _____

Continued Over...

• **NAME OF YOUR G.P. OR MEDICAL CENTRE:** _____

• **PLEASE LIST ALL MEDICATIONS being taken as these may interfere with your dental treatment.**

_____

_____

These may include: Aspirin, Oral Contraception, HRT, Steroids, Warfarin or other blood thinning medicine, medication for depression, any herbal or naturopathic medications, any 'over the counter' medications.
If you're in any doubt about your medication, please bring the bottle/packet to the practice to show the dentist.

• **PLEASE LIST ANY ALLERGIES YOU MAY HAVE (medicines, foods, chemicals & substances)**
These may include: penicillin or other antibiotics, chlorine, latex, antiseptics etc.

_____

_____

• **DO YOU SUFFER FROM ANY OF THE FOLLOWING?**

ASTHMA YES ◯
BLOOD THINNING YES ◯
BLOOD DISORDERS YES ◯
BLOOD PRESSURE ISSUES YES ◯
DIABETES YES ◯
EPILEPSY YES ◯
HEART/VASCULAR DISORDER YES ◯
HEPATITIS, LIVER DISEASES YES ◯
JOINT REPLACEMENT SURGERY YES ◯
OSTEOPOROSIS YES ◯
PACEMAKER FITTED YES ◯
RHEUMATIC FEVER YES ◯
THYROID YES ◯

CURRENT CANCER TREATMENT YES ◯
PREVIOUS CANCER TREATMENT YES ◯
SURGERY (LAST 6 MONTHS) YES ◯
IF YES – STATE DETAILS: _____
_____

DO YOU SMOKE? YES ◯ NO ◯
IF YES – HOW MANY? _____

ARE YOU PREGNANT? YES ◯ NO ◯
IF YES – STATE DUE DATE: _____
ARE YOU BREASTFEEDING? YES ◯ NO ◯

• **NAME ANY MEDICAL CONDITIONS NOT MENTIONED ABOVE:** _____

_____

Declaration: In signing this form I acknowledge that this represents an accurate personal and medical history and I understand that this information will be treated with complete professional confidentiality.
I will advise my dentist of any changes to my medical or personal history in the future.

PATIENT SIGNATURE: _____ **DATE:** _____
Parent or guardian if patient is under 18 years.

Office use only:

UPDATED: _____ CHANGES ◯ NONE ◯
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PATIENT CARD #: _____ PROVIDER: _____