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 ◯

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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.**

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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.

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• **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: ______________________________

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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:** ______________________________

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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:

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PATIENT CARD #: ______________________________ PROVIDER: ______________________________