GREENVALE DENTISTRY

Welcome to our practice. For our confidential records, and to assist in determining your treatment, please answer the following questions as accurately as possible. Failure to make a full disclosure may place you at undue medical risk.

YOUR DETAILS:

Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Surname……

First Name……Preferred Name…….

Date of Birth …./…./….

Address…….

Suburb……..Post Code……..

Home Phone: ……..Business Phone……..Mobile……

Email Address……..

Please tick box if you do NOT wish to receive special promotions and communications by email ☐

Occuption……..Employer……

Emergency Contact……Contact Number……

Person Responsible for fees ……..

DENTAL INFORMATION:

What is the purpose of your visit today? ……

……

Have you had any problems with past dental treatment? ☐

If ticked yes, please explain……

……

How did you hear about the practice? ……..

Do you have private dental Health Cover? Yes ☐ No ☐ If so which one ……

CONFIDENTIAL HEALTH INFORMATION:

Have you had any medical problems in the last year? Yes ☐ No ☐

If ticked yes, please specify……

Name and address of your general Medical Doctor……..

……Phone Number……

When did you last visit your doctor?……

Do you currently, or have you ever suffered from any of the following conditions?

Rheumatic Fever	☐	Asthma	☐	Chemotherapy/Radiotherapy	☐
Diabetes	☐	Epilepsy	☐	Heart Ailments	☐
Hepatitis	☐	Malaria	☐	Stroke	☐
Kidney Disease	☐	Angina	☐	Blood Pressure Low/High	☐
Artificial Joints/Valves	☐	Blood Disorders	☐	Organs Transplants	☐
Arthritis	☐	Pacemaker	☐	Tuberculosis	☐
Cholesterol	☐	AIDS/HIV	☐		

Are you currently pregnant or breastfeeding?……

Do you have any drug or dietary allergies? (eg: penicillin, codeine, nickel, latex) . Please Specify…….

……

……..

Have you ever had an unfavourable reaction to local anaesthetics? Yes ☐ No ☐

Have you ever taken or been given medication for Osteopenia or Osteoporosis? Yes ☐ No ☐

Are you currently taking any medications? Yes ☐ No ☐

If you answered yes, please list……

……..

Do you smoke? Yes ☐ No ☐ If so, how many a day?……..

I have completed this questionnaire to the best of my knowledge.

I understand that payment is required on the day of treatment. My Preferred method of payment is;

Cash ☐ Cheque ☐ EFTPOS ☐ Visa ☐ Mastercard ☐

Signature……..Date……

Failure to give 24 hours' notice for appointment changes may incur a cancellation fee.