HARTER
family dental care

WELCOME TO OUR PRACTICE
Please answer these questions as completely as possible.
It will assist us to provide the best dental treatment for you.

PATIENT PERSONAL & MEDICAL QUESTIONNAIRE – PRIVATE & CONFIDENTIAL

PRIVACY STATEMENT: We value your privacy.
All of the information which you provide to us will be held and used by us in accordance with our Privacy Policy. A copy of our Privacy Policy is attached to this Questionnaire. Please take the time to read through our Privacy Policy before answering the Questionnaire and speak to one of our staff members if you have any concerns about how we will use your personal information.

Name (Mr/Mrs/Miss/Ms/Dr/Other) _____

Address _____ Postcode

Date of Birth _____ Phone (Home) _____ Phone (Work) _____

Phone (Mobile) _____ Preferred Daytime Contact: Home / Work / Mobile

Email _____

Occupation _____ Employer _____

Emergency Contact _____ Relationship _____ Phone _____

Person responsible for payment of accounts _____

Private Health Fund (if applicable) _____

Medicare Number _____ and ID Number _____

Whom may we thank for recommending you to our practice _____

The state of your health may have a very significant effect on your dental care.
Please answer these questions fully or discuss them with your dentist:

	Y	N
• I have private and confidential medical matters which I wish to discuss with the dentist	☐	☐
• Are you receiving any medical treatment at present? _____	☐	☐
• Name of your medical practitioner/specialist _____		
• Have you ever been in hospital? If yes, nature of hospitalisation and dates:	☐	☐

_____

_____

Some medicines may interfere with your dental treatment or react with medicaments used by your dentist. It is important that your dentist knows precisely what medications (if any) that you are taking.

Please list any medications you are currently taking, or have been taking recently including herbal remedies, vitamins, supplements, cold/flu treatments, sleeping pills, pain relievers, injections, implants, so we can take appropriate precautions and avoid drug interactions.

Drug Name	Dosage	Duration of Treatment	Purpose/Condition

Please list any known ALLERGIES or ADVERSE REACTIONS to drugs (especially antibiotics eg. penicillin), medicines, antiseptics, local anaesthetics, preservatives that we should know about.

Drug Name	Nature of Reaction	How Long Ago

If you are in any doubt about your medication, please bring a Pharmacy Medication Summary or the bottle or packet(s) to the practice to show the dentist.

PLEASE TURN OVER ►

Please indicate YES or NO if you have ever had any of the following:

	Y	N
Rheumatic fever	☐	☐
Heart condition/cardiac surgery/pacemaker	☐	☐
Heart valve replacement	☐	☐
High or low blood pressure	☐	☐
Blood disorders	☐	☐
Excessive bruising or bleeding	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Kidney/renal disease	☐	☐
Diabetes or family history of diabetes	☐	☐
Osteoporosis or low bone density	☐	☐
Rheumatoid arthritis/Lupus (SLE)/Polymyalgia	☐	☐
Joint replacement surgery	☐	☐
Jaw, neck or shoulder injury or pain	☐	☐
Epilepsy/Seizures	☐	☐

	Y	N
Thyroid disease (including goitre)	☐	☐
Tuberculosis (TB)	☐	☐
Asthma/Bronchitis/lung conditions	☐	☐
Nervous system disorder	☐	☐
Anxiety/Depression	☐	☐
Gastroesophageal reflux disease (GORD)	☐	☐
Treatment for cancer (type/region)	☐	☐
	☐	☐
Chemotherapy/Radiation therapy	☐	☐
Allergy to any foods, chemical or substance	☐	☐
(eg. chlorine/latex/elastoplast)	☐	☐
Transplanted organ/bone marrow/stem cells	☐	☐
Snoring/Sleep Apnoea	☐	☐

Have you ever smoked? Y ☐ N ☐ Approx date if quit _____ Do you currently smoke? Y ☐ N ☐

If yes, for how long? _____ How much do you smoke? _____ per day

Have you used illicit substances or recreational drugs? Y ☐ N ☐ If yes, when? Recent ☐ Over 1yr ago ☐

Have you ever required any treatment for smoking related diseases or conditions? Y ☐ N ☐

Do you suffer from any illness not listed above or carry any infectious disease? Y ☐ N ☐

If yes, please provide details _____

FEMALES: Are you pregnant or is there a chance you could be pregnant? Y ☐ N ☐ If yes, date due _____

Are you currently breastfeeding? Y ☐ N ☐

DECLARATION:

In signing this form I acknowledge that this represents an accurate medical history.
I will advise my dentist of any changes to my medical history in the future.
I understand that all medical details will be treated with complete professional confidentiality.
I have read the privacy document provided by this practice.

Patient Signature _____ Date _____
(Parent or guardian if under 18 years)

Dentist Signature _____ Date _____

PRACTICE USE ONLY: REVIEW OF INFORMATION

Patient Signature _____ Date _____

Dentist Comment _____ Date _____

Signature _____

Patient Signature _____ Date _____

Dentist Comment _____ Date _____

_____ Signature _____

Patient Signature _____ Date _____

Dentist Comment _____ Date _____

_____ Signature _____