



**NEW PATIENT QUESTIONNAIRE**

**In the interest of your treatment, all questions must be answered to the best of your knowledge. All information is kept strictly confidential.**

Surname..... Title: (Mr, Mrs, Miss, Ms, Dr, other).....

First name..... Other Names.....

D.O.B \_\_\_/\_\_\_/\_\_\_\_\_

Phone (h)..... (w)..... (mob).....

Address.....

Suburb..... P/code.....

Email.....

Occupation.....

Are you a member of a Health Fund: yes/no Which Fund? {eg MBF,HCF etc}.....

Would you like to be included on our email list?..... yes/no

Would you like to be included on our sms list?..... yes/no

Would you like to receive a reminder every 6 months yearly none

**How did you hear about us?**

- 1. yellow pages online
- 2. yellow pages book
- 3. signs
- 4. friends/family
- 5. advertisements
- 6. Website
- 7. other.....

If you were recommended by someone, who were they so that we may thank them?

.....

## MEDICAL and DENTAL HISTORY

Do you currently have, or have had any history of:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Prosthetic Heart Valves	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Hepatitis A,B, or C
<input type="checkbox"/> Aids/HIV	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Smoke	<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Sinus Problems

Any other illnesses ?    yes/no            Please explain .....

.....

Are you taking any medications ?    yes/no            Please list .....

.....

Have you been in hospital recently ?    yes/no            Please explain.....

Are you allergic to penicillin ?            yes/no            Any Other Allergies? .....

Are you pregnant ?    yes/no            months?.....

Please describe what you would like to achieve from your visit today?  
 (relief of pain, optimising oral health, optimising cosmetics, etc)  
 .....  
 .....

Are you happy with the cosmetic appearance of your smile?            yes/no  
 If not, explain what you do not like or what you would like to improve  
 .....  
 .....

Have you ever thought of whitening your teeth?            yes/no

When was the last time you visited the dentist?.....

**Payment** for services are required on the day of treatment, unless otherwise discussed with by the treating dentist. We have the **Hicaps** facility where we can claim for your benefits directly from your health fund. We also accept **Credit card** and **Cash**. We also offer **Interest Free** and **Payment Plans** from **Care Credit**, feel free to discuss this option with us. Unfortunately we do not accept personal cheques.

The practice requires at least 24 hours notice of any cancellations, failure to do so will incur a \$50 cancellation fee.

Any x-rays or pictures taken of you or your teeth may be used for teaching or marketing purposes. Your identity will remain confidential unless otherwise discussed with you by Dr Saade. If you have any concerns, feel free to bring it up with us.

Signature.....

Date \_\_\_/\_\_\_/\_\_\_\_\_