WELCOME TO (02) 9556 2000

MINIMUM INTERVENTION MAXIMUM RESULTS

Please answer and sign questions 1 to 32.
We would appreciate if you answer the additional questionnaire as this will be beneficial to your dental treatment.
Please be assured that all information is treated with complete professional confidentiality.

Title: O Mr O Mrs O Ms O Other .... Birth Date: ..../.............../20................
First Name(s): .... (Preferred Name)
Family Name: ....
Address: .... (Street) .... (State or Country)
.... (Suburb) .... (Postcode or Zip)
Contacts: .... (Home Phone) Occupation: ....
.... (Work Phone) Preferred Language: ....
.... (Mobile) .... (Email)
.... (Other eg Facebook, Twitter)

16. Emergency Contact: .... (Name)
.... (Home/Work/Mobile)
17. Who is your General Practitioner? ....
.... (Name/Suburb/Phone)
18. Do you have dental insurance? O BUPA O HCF O MP O NIB O SMILE O VetAffairs
O Other ....
19. Accounts are settled on the day of treatment. What is your preferred method of payment?
O Cash O Credit Card O Eftpos O Finance O Cheque O Other ....
20. Do you or have you ever suffered from heart conditions or elevated blood pressure problems?
[ ] Yes [ ] No [ ] Hypertension/Blood Pressure [ ] Pacemaker [ ] High Cholesterol [ ] Irregular Heart Beat
[ ] Enlarged heart [ ] Rheumatic Fever [ ] Cardiac Surgery [ ] Heart Attacks [ ] Artificial Valves [ ] Murmur
[ ] Other ....
21. Have you ever had: [ ] any cancers [ ] radiotherapy [ ] chemotherapy ? ....
22. Any major traumas or fractures to head or neck ? ....
....
23. Any major hospitalisations ? ....
....
24. Any allergies/rashes/hypersensitivities or adverse drug reactions ? [ ] No [ ] Yes
O Costume jewellery O Latex O Antibiotics O Iodine O Sulpha O Bee stings O Seafood O Nuts
O Other ....
25. Are you pregnant or possibly pregnant? [ ] No [ ] Yes (............... months)
26. Do you suffer or have you ever suffered from: [ ] Diabetes [ ] Osteoporosis [ ] Anaemia [ ] Osteoarthritis
[ ] Nervous conditions/Anxiety/Depression [ ] Gastro Intestinal Disorders [ ] GORD [ ] Bulimia [ ] Epilepsy
[ ] High Cholesterol [ ] Thyroid problems [ ] Liver disease [ ] Kidney disease [ ] Asthma
[ ] Any other medical conditions ....
27. Do you have or have you ever had: [ ] Hepatitis A,B,C,D or E [ ] Meningococcal infections [ ] CJD [ ] Tuberculosis
[ ] Whooping Cough [ ] MRSA Methicillin Resistant Staph Aureus [ ] HIV/AIDS
[ ] Any other Infectious Diseases? ....
28. Have you ever injected illegal drugs? [ ] Yes [ ] No
29. Are you of Aboriginal or Torres Strait Island descent? [ ] No [ ] Yes ....
30. Please list ALL medications you are taking? ....
....

31. Please list medications you are required to take prior to receiving treatment ....

....

32. Have you ever been: [ ] prescribed bisphosphonate medication eg Fosamax, Actonel, Bonviva?
[ ] treated for postmenopausal osteoporosis, Paget's Disease or metastatic bone disease arising from breast cancer?
[ ] Don't know

Date: ..../..................../...................... Signature: ....

Non Mandatory Questions:

33. Have you ever had "Botox", "Dysport" or dermal fillers? [ ] Yes [ ] No
34. At present my life is: [ ] stress free [ ] normal [ ] extremely stressful
35. Have you ever been told or do you think you: [ ] snore [ ] grind your teeth while sleeping
36. My overall health is? [ ] Excellent [ ] Fair [ ] Poor [ ] don't know ....
37. Do you smoke? [ ] No [ ] a little [ ] a lot
38. Do you drink alcohol? [ ] No [ ] a little [ ] a lot
39. Soft/sport/energy drinks? [ ] No [ ] a little [ ] a lot
40. Tea/coffee/red wine? [ ] No [ ] a little [ ] a lot
41. How many teaspoons of sugar? [ ] no sugar [ ] one [ ] more than one ....
42. I eat chocolate [ ] never [ ] only sometimes [ ] every day
43. Do you know your: cholesterol level? .... [ ] less than 3.3 [ ] 3.3 – 5 [ ] greater than 5
blood pressure? ....
44. Have you ever had your thyroid gland tested? [ ] Yes [ ] No
45. How much water do you drink on average per day? .... L [ ] None [ ] 1-2 [ ] > 3 glasses
46. Have you ever: [ ] had an acidic feeling in the mouth [ ] had dry mouth [ ] sucked lemons
47. My favourite snacks between meal times are: O None O Biscuits O Lollies O Fruit O Nuts O Chips
O Other...
48. Do your gums bleed on brushing? [ ] I dont brush my gums [ ] Never [ ] Sometimes [ ] Always
49. On average how many times a day do you brush your teeth? [ ] 1 [ ] 2 [ ] 3 [.........] more
50. For how long? [ ] less than 1 minute [ ] two minutes [ ] three minutes [.........] more
51. I mainly use: [ ] a manual brush [ ] electric brush
52. My brush is: [ ] soft [ ] medium [ ] hard
53. Do you clean between your teeth? [ ] Yes [ ] No
54. Do you clean your tongue? [ ] Yes [ ] No
55. Do you have any: [ ] Major fears O Needles O Spiders/Snakes O Enclosed Spaces O Other ....
[ ] Obsessive behaviours [ ] No [ ] Yes .... O Bite nails
56. How did you find us? O Internet O Expo O Other O Referral .... who? so we may thank them
57. [ ] I am a regular dental patient [ ] I only attend if I need to
58. Visiting the dentist makes me feel: [ ] Good [ ] Neutral [ ] Stressed [ ] Very Stressed
59. My last visit was: .... for: .... O Check Up O Pain O Other
60. Do you have any problems with needles? [ ] No [ ] Yes O fear O they don't work O they hurt
O other..
61. Why are you here? [ ] Health Assessment/ Check up [ ] Clean [ ] Treatment of Pain [ ] Improving Function
[ ] Aesthetic [ ] Other ....
62. Do you have: [ ] holes/decayed/broken teeth [ ] loose teeth [ ] sharp pain on biting [ ] sore gums [ ] bad breath
[ ] bleeding gums [ ] painful or clicking/noisy jaw joints [ ] worn teeth [ ] swellings/infections [ ] loose dentures
[ ] sensitivity to cold [ ] eating difficulties [ ] headaches [ ] food traps [ ] crooked/crowded teeth
[ ] discoloured teeth [ ] Other ....
63. Are you: [ ] happy/ confident with your smile? [ ] not happy? [ ] not sure? ....
64. Any questions or comments? Please let us know: ....

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