GLADSTONE DENTAL CENTRE

Welcome to Gladstone Dental Centre

To help us give you the best possible treatment, please answer the following *confidential* questions to help us get to know you better and understand your dental needs.

Title: Dr / Mr / Mrs / Ms / Miss / Master *(please circle)*

Date of Birth: ____/___/_____

Surname: _____

Contact Number:_____

First Name: _____**Preferred Name:**_____

Email:_____

Address: _____

Medicare Card Number:_____

_____

Appointment Reminder: *Phone / SMS / Email / No thanks*

Suburb: _____**Postcode:**_____

☐ *Opt out of communications (e.g. email newsletters)*

Occupation:_____

GP Details:_____

Are you covered for Dental by a health fund? *Membership #*	☐ Yes, *fund name*: *Your number on card:*	☐ No
Are you currently receiving medical treatment?	☐ Yes, *details*:	☐ No
Are you currently taking **any** medications?	☐ Yes, *details*:	☐ No
Are you on any medication/injections for **bone weakness/osteoporosis?**	☐ Yes	☐ No
Have you ever suffered a serious illness?	☐ Yes, *details*:	☐ No
Do you have **any** allergies? *(foods/medicines/latex)*	☐ Yes, *details*:	☐ No
Have you had any dental treatment in the past that you would like us to know about?	☐ Yes, *details*:	☐ No
Do you have any abnormal reactions to local or general anesthesia?	☐ Yes, *details*:	☐ No
Have you taken aspirin in the past two days?	☐ Yes	☐ No
Have you taken steroids in the last two years?	☐ Yes	☐ No
Are you pregnant or breastfeeding? *(females only)*	☐ Yes	☐ No
Do you normally require antibiotic cover before dental treatment?	☐ Yes	☐ No

Please tick if you have or have had any of the following:

- ☐ Heart attack, disease, surgery, murmur, disorder or complaint
- ☐ Cardiac pacemaker
- ☐ High or low blood pressure
- ☐ Angina
- ☐ Respiratory disease
- ☐ Bruise/bleed excessively
- ☐ Artificial joints
- ☐ Epilepsy
- ☐ Transplants
- ☐ Kidney/liver disease
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Bone disease
- ☐ Blood disease
- ☐ Lung disease
- ☐ Radiation Therapy
- ☐ Cancer
- ☐ Asthma
- ☐ Hepatitis (A / B / C)
- ☐ HIV or AIDS
- ☐ Diabetes
- ☐ Rheumatic fever
- ☐ Thyroid disease

How did you hear about us? *(please circle)* Google online search / Yellow Pages / Facebook / Signage / Newsletter / Qld Health / Health fund /Friend or word of mouth / Other Promotion _____

Please Note:

- ✓ Payment is required at the end of all visits, as we do not operate accounts.
- ✓ The information you have provided is handled in accordance with the Privacy Policy established by the Australian Dental Association.
- ✓ If you must cancel your appointment, we require 24 hours notice or a cancellation fee may apply.
- ✓ You are giving consent to be examined and/or treated by our dental staff.
- ✓ You are giving consent to our Dental Staff to take; x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis.
- ✓ You understand that using anesthetic agents embodies certain risks. You can ask for an explanation of possible complications.

Patient Signature: _____ **Date:** _____/_____/_____

*Parent/Guardian Name:*_____

(Parent/Guardian please sign and write full name if the patient is under 18 years of age)

Thank you!