



## Welcome to Dental Centre Gladstone

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-our protocol is to update these every year so please do not be offended if we ask for an update!

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

**Surname:** \_\_\_\_\_

**First Name:** \_\_\_\_\_

**Preferred Name:** \_\_\_\_\_

**Date Of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Occupation:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Suburb:** \_\_\_\_\_ **Postcode:** \_\_\_\_\_

**Mobile:** \_\_\_\_\_

**Home Number:** \_\_\_\_\_

**Work Number:** \_\_\_\_\_

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

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

Are you Covered by a Health Fund?  Yes, details: \_\_\_\_\_  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/cancer**?  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? (As advised by cardiologist or GP)  Yes  No

Do you smoke?  Yes  No

When was your last Dental Check up?.....

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Heart attack, disease, surgery, murmur, disorder or complaint | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Radiation Therapy     |
| <input type="checkbox"/> Cardiac pacemaker   | <input type="checkbox"/> Transplants          | <input type="checkbox"/> Cancer                |
| <input type="checkbox"/> High or low blood pressure                                    | <input type="checkbox"/> Kidney/liver disease | <input type="checkbox"/> Asthma                |
| <input type="checkbox"/> Angina  | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Hepatitis (A / B / C) |
| <input type="checkbox"/> Respiratory disease   | <input type="checkbox"/> Stroke               | <input type="checkbox"/> HIV or AIDS           |
| <input type="checkbox"/> Bruise/bleed excessively                                      | <input type="checkbox"/> Bone disease         | <input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Artificial joints   | <input type="checkbox"/> Blood disease        | <input type="checkbox"/> Rheumatic fever       |
|  | <input type="checkbox"/> Lung disease         | <input type="checkbox"/> 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 (please tell us who) \_\_\_\_\_  
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!**