



Welcome to Dental Centre Maleny

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: _____

Phone: _____

First Name: _____

Mobile: _____

Address: _____

Email: _____

Suburb: _____

Post code: _____ Occupation: _____

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

Are you covered by a health fund? Yes, fund name: _____ No

Are you currently receiving medical treatment? Yes, details: _____ No

Are you currently taking any medications? Yes, details: _____ No

Have you ever suffered a serious illness? Yes, details: _____ No

Do you have any allergies? 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 anaesthesia? 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 a smoker? 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:

- | | | |
|--|---|--|
| <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 |
| <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 are you feeling about your visit today? (please circle)

At Ease 2 3 4 5 6 7 8 9 Very Anxious

How did you hear about us? (Please circle)

Google online search / Social Media (Facebook - Google - Other) / Signage / Newsletter / Newspaper / 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 (ADA).
- ✓ 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.

Patient Signature: _____
(Parent/Guardian please sign if the patient is a child under 18 years of age)

Date: ____/____/____

Thank you!