NORTHSIDE
DENTAL AND IMPLANT
CENTRE

C O N F I D E N T I A L N E W P A T I E N T Q U E S T I O N N A I R E

Mr/Mrs/Miss/Ms/Dr/Prof/Other……: Surname _____First Name:_____

Address: _____Suburb: _____ Post code: _____

Date of birth: _____/____/_____ Veterans' DVA No: NX _____

Phone: Home: _____ Work: _____ Mobile: _____

Email address:_____

Emergency contact: Name: _____ Phone_____

Private health cover: _____

Person responsible for this account, if different to above: _____

Do you feel nervous about dental treatment? _____

Who referred you to this practice? _____

M E D I C A L H I S T O R Y

Name of general practitioner: _____
Address: _____
Name of any medical specialists: _____
Address: _____

D o y o u h a v e a n y o f t h e f o l l o w i n g ?

Allergies to any drugs or medications: _____
Heart valve replacement: _____
Bleeding disorders: _____
Have you ever had rheumatic fever? Yes No
Could you be pregnant? Yes No
Do you have or have you ever had:

	Yes	No		Yes	No
Chest pain	❑	❑	Asthma	❑	❑
Heart murmur	❑	❑	Tuberculosis	❑	❑
Oedema	❑	❑	Cough regularly	❑	❑
High blood pressure	❑	❑	Have you ever smoked?	❑	❑
Heart attack	❑	❑	Quit, when?	_____	
If yes, when?	_____		Liver disease	❑	❑
Stroke	❑	❑	Hepatitis and type	❑	❑ ____
Arthritis	❑	❑	HIV infection	❑	❑
Diabetes/type	❑	❑ ____	Radiotherapy	❑	❑
Epilepsy	❑	❑	Chemotherapy	❑	❑
Kidney disease	❑	❑	Osteoporosis	❑	❑

	Yes	No	
Do you take recreational drugs?	❑	❑	_____
Do you sleep in an elevated position?	❑	❑	_____
Can you walk up a flight of stairs?	❑	❑	_____
Have you ever had a general anaesthetic?	❑	❑	_____
Were there any complications?	❑	❑	_____

Other medical problems: _____
List current medications and injections including herbal medicines:_____
_____
Additional comments:_____
_____

I **agree/do not agree** to a photograph being taken of me/my ward for patient identification purposes.

Signature: _____

Guardian/carer signature: _____Date: _____