Hawksburn Village Dental

Welcome to Hawksburn Village Dental. So that we may provide you with the best possible care, please complete both sides of this questionnaire. All information is completely confidential.

Full Name: _____ Title:_____
Date of Birth:_____

Address:_____
_____
Suburb:_____ Post code: _____

Email Address: _____
Home Phone:_____
Mobile Phone: _____
Occupation: _____

Person responsible for account:_____
Do you belong to a dental fund: Yes/No Which healthfund? _____

Emergency contact: _____
Name & contact details of your GP? _____

Who referred you to our dental practice? _____
Did you discover our practice through (Please circle) Google / Website / Walk Past / Signage
Other_____

What is the reason for your visit today? _____

Please circle the approximate time period since your last dental visit: (Please circle)
0-3 months 4-6 months 7-12 months 12 months or longer _____
How often do you seek professional help to keep your teeth clean?
3 monthly 6 monthly yearly when required

Dental Health Habits (Please circle or indicate what is usual for you)

Tooth brushing frequency: after every meal / twice daily / daily / weekly / never
Dental flossing frequency: daily / weekly / when food gets stuck / don't use floss
Do your gums bleed when brushing or flossing? Yes / No

Are any of your teeth sensitive to hot / cold / sweets / pressure
To your knowledge, do you clench or grind during the day / night? Yes / No
Do you experience headaches regularly? Yes / No

Would you like to discuss cosmetic options with the dentist further? _____
Whiter / Straighter / Shorter / Longer / Close the gaps / More even

Do you feel nervous about dental treatment? If so, what is your biggest concern?
_____
_____

Please turn over

CONFIDENTIAL MEDICAL HISTORY

Have you ever had any serious illnesses, operations or infectious diseases? Yes / No
If yes, please give details _____

Have you ever had, or do you suffer from any of the following? (Please tick)

Rheumatic fever	❒	Asthma	❒	Any heart condition	❒
Diabetes	❒	Epilepsy	❒	Pacemaker	❒
Hepatitis A, B, C	❒	HIV/Aids	❒	Stroke	❒
Blood pressure-high/low	❒	Tuberculosis	❒	Cancer past/current	❒
Depression/anxiety	❒	Osteoporosis	❒	Bleeding disorder	❒

Are you at present receiving medical treatment? If so, what for
_____

Is Snoring a problem for you or your partner? Yes/No

Do you wake feeling unrefreshed? Yes/No

Are you sleepy during the day? Yes/No

Has anyone heard you gasp or stop breathing during sleep? Yes/No

Have you been diagnosed with sleep apnoea? Yes/No

Are you under or intending treatment using bisphosphonate medication? Yes / No

Please list any current medications_____
_____
_____
Do you smoke or take other recreational drugs? Yes / No
Ladies, are you pregnant? Yes / No / Maybe (If so, what is your due date?_____)

Do you have a prosthetic heart valve, hip, knee or other implant? Yes / No _____

Are you allergic to any drugs or medicines? _____
Do you have an unfavourable reaction to local anaesthetic or latex? Yes / No

Is there anything you would like discuss privately with the dentist? Yes / No

Privacy Policy Act

The practice adheres to the ADA privacy policy. If you wish to see a copy of this policy, it is available through the ADA. These records are collected for purposes relevant to your dental care.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. I will notify the dentist of any

change to my health or medication.

I understand that failure to complete the medical information may place me and others at medical risk.

Patient / Guardian Signature:_____ Date: _____