

Welcome to Rockingham Dental Centre

Thank you for answering these questions to the best of your knowledge. They are designed to allow us to ensure our treatment is compatible with your present state of health.

Title: _____ Surname: _____ First Name: _____

Preferred Name: _____ Date of Birth: _____

Street Address: _____

Postal Address (if different to street address): _____

Home Phone: _____ Mobile: _____

Occupation: _____ Employer: _____ Work Phone: _____

Email: _____

Dental Insurance: Yes No Fund Name: _____ Membership #: _____

Patient ID #: _____

Family Doctor's Name: _____ Medicare #: _____ Patient ID #: _____

Next of Kin Name: _____ Next of Kin Phone: _____

Next of Kin Address: _____

How did you find out about us? Google Search Website Yellow Pages Friend Relative

Other: _____

If you do not wish to receive our eNewsletter, please tick to opt out

We value your privacy. All of the information which you provide to us will be held and used by us in accordance with our Privacy Policy. A copy of our Privacy Policy is attached to this Questionnaire. Please take the time to read through our Privacy Policy before answering the Questionnaire and speak to one of our staff members if you have any concerns about how we will use your personal information.

SECTION A – Do you have – please tick:

High blood pressure: Yes No

Heart problems: Yes No

Angina Prosthetic heart valve Cardiac pacemaker Other: _____

Allergies: Yes No

Penicillin Local anaesthetic Codeine Aspirin Latex Other: _____

A long-standing illness: Yes No

Diabetes Epilepsy Goitre Blood disorder Asthma Kidney disease

Other: _____

A bone disease: Yes No

Osteoporosis Paget's disease Bone cancer Multiple myeloma Other: _____

Have you taken bisphosphonate medication for any bone diseases in the last 10 years? Yes No

Alendronate (Fosamax) Risedronate (Actonel) Pamidronate (Aredia, Pamisol) Xgeva (Denosumab)

Zoledronate (Zometa) Etidronate (Didrocal) Clodronate (Bonefos) Tiludronate (Skelid)

Other: _____

Bleeding problems: Yes No

Spontaneous bleeding Prolonged bleeding after surgery or injury Other: _____

A family history of any illnesses: Yes No

Diabetes Heart disease Other: _____

A snoring problem: Yes No

SECTION B – Are you:

A smoker: Yes No

Possibly pregnant: Yes No

Taking any anti-coagulants: Yes No

Aspirin Warfarin Clopidogrel Pradaxa Other: _____

Receiving medical treatment of any kind: Yes No

Please specify: _____

Have you been hospitalised in the last 12 months: Yes No

Taking any other medicines or drugs: (including prescription, 'over the counter' & recreational drugs) Yes No

Please list: _____

SECTION C – Have you ever had:

Any problems with Local or General Anaesthesia: Yes No

Please specify: _____

A joint replacement: Yes No

Please specify: _____ Date/year of surgery: _____

Rheumatic fever: Yes No

A heart attack: Yes No

A stroke: Yes No

Radiation treatment (not films): Yes No

Radium or cobalt treatment: Yes No

Hepatitis: Yes No

Jaundice: Yes No

Cortisone treatment: Yes No

A gastric ulcer: Yes No

Popping, clicking or pain in your jaw joints: Yes No

Please specify: _____

PATIENT DECLARATION

- I agree to advise the Dentist if I have any change to my medication or medical condition.
- I agree that if I do not pay my account within normal trading terms, you may recover from me all the reasonable costs incurred in collecting that debt.
- By signing below I am confirming that all the information shown on this form is true and correct at the time of my visit.

Patient's Signature: _____ Date: _____

PATIENT DECLARATION (future updates only)

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Save form to computer
before pressing Email Form