SDC SPECIALIST DENTAL CENTRE

Tel (02) 4721 7777
Fax (02) 4744 3667
Email drs@specialistdental.com.au

24 Colless Street
Penrith 2750 NSW
www.specialistdental.com.au

Patient Personal & Medical Questionnaire
Private & Confidential

Privacy Statement

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. A copy of our policy is attached to this questionnaire.

Mr., Mrs., Miss., Ms., Dr., (Other) | Surname | Given Names

Address

Post Code

Date of Birth / /

Email Address

Occupation

Preferrred Daytime Contact: Home / Work / Mobile

Phone (Home) | Phone (Work) | Phone (Mobile)

Person Responsible for Accounts | Relationship | Emergency Contact

Private Health Fund | Card Number | Patient Number

Hospital Cover: Yes / No

Dental Cover: Yes / No

DVA Number (If Applicable)

Medicare Card Number | Patient Number | Expiry Number

Whom may we thank for referring you to our practice?

Name of Dental Practitioner (If different from above)

Name of General Practitioner

Phone

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The state of your health may have significant effects on your dental care.
Please answer these questions fully or discuss them with your specialist.

I have private & confidential medical matters which I wish to discuss with the specialist	Yes / No
Are you receiving any medical treatment at present?	Yes / No
Have you ever been in hospital? If yes, nature of hospitalisation and dates	Yes / No

Date

Do you currently smoke? If yes, for how long and how many a day?	Yes / No
Have you ever smoked? If yes, approximately how long ago?	Yes / No
Have you ever required any treatment for smoking related diseases or conditions?	Yes / No
Have you ever used illicit substances and/or recreational drugs? If yes, for how long?	Yes / No
Are you pregnant or is there a chance you could be pregnant? If yes, approx. due date	Yes / No
Are you currently breast feeding?	Yes / No
Are you currently taking any medication? If yes, please list attached table (See back page)	Yes / No
Do you have any allergies? If yes, please list on attached table (See back page)	Yes / No

Please indicate Yes or No, if you have ever had any of the following:

Rheumatic Fever	Yes / No
Heart Condition/Cardiac Surgery including HVR/Pacemaker, if yes please state	Yes / No
High or Low Blood Pressure, if yes please state	Yes / No
Diabetes (Type 1 or Type 2), if yes please state	Yes / No
Blood disorders, if yes please state	Yes / No
Excessive bruising or bleeding	Yes / No
Osteoporosis or low bone density	Yes / No
Rheumatoid Arthritis/Lupus/Polymyalgia, if yes please state	Yes / No
Joint Replacement Surgery, if yes please state when	Yes / No
Hepatitis, Jaundice or Liver disease, if yes please state	Yes / No
History of Fits or Epilepsy	Yes / No
Gastroesophageal Reflux Disease (GORD)	Yes / No
Treatment for Cancer (type/region), if yes please state	Yes / No
Chemotherapy/Radiation thereapy, if yes please state	Yes / No
Do you suffer from any illness not listed above?	Yes / No

If yes, please provide further details

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Patient Signature | Date

(Parent or Guardian if under 18 years old)

Some medicines may interfere with your dental treatment or react with the medicaments used by your specialist. It is important that your specialist knows precisely what medication (if any) that your are taking. Please list any medication you are currently taking, or have been taking recently including herbal remedies, vitamins, supplements, cold/flu, treatments, sleeping pills, pain relievers, injections, implants, so we can take appropriate precautions.

Drug Name	Dosage	Duration of Treatment	Purpose/Condition

Please list any known ALLEGIES or ADVERSE REACTIONS to drugs (Especially antibiotic eg. Penicillin), medication, antiseptics, local anaesthetics, preservatives that we should know about.

Drug Name	Nature of Reaction	How Long Ago

If you are in any doubt about your medication, please bring a Health Care Summary from your General Practitioner or the bottle or pockets (S) to the practice to show your specialist.

Declaration

In signing this form, I acknowledge that this represents an accurate medical history. I will advise my specialist of any changes to my medical history in the future.
I am happy for reports on my condition to be sent to my referring doctor/dentist.
I am happy for copies to be sent to relevant health professionals involved in my care: Yes / No
I understand that all medical details will be treated with complete professional confidentiality.
I have read the privacy policy overleaf. I understand that my information will be held in the consulting rooms. I am aware of the financial policy of the practice.