coral coast dental

living smiles

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Phone: 4154 7122
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Confidential Patient Questionnaire

This provides the Dentists with important information required for your Dental Treatment and Oral Health Care, which needs to be filled out every 12 months.

Name:____D.O.B__________________________
Title First Names Surname

Home Address:____

Postal Address:____

Email Address:____

Phone Number:_________________________________ Alternative Number:___________________________

Occupation:_______________________ Work Address:____

Medicare Card Number:___________________________ Reference Number:______ Expiry Date: ____________

Do you have ***Private Health Insurance*** covering dental expenses? Yes / No ***Name of Fund***:______________________

Do you have a ***GOLD Veteran's Affairs card***? Yes / No ***File No***:___________________________

Details of person to contact in an ***Emergency***: Name:___________________ Phone Number:_________________

Do you give Coral Coast Dental permission to speak to your emergency contact in regards to your treatment, including specialist calls, courtesy calls and information to do with your treatment? Yes / No

Medical Doctors Name: ____ Phone Number: __________________

MEDICAL HISTORY

1. Are you receiving any medical treatment at the present time? Yes / No
   Details:____
2. Have you been a patient in hospital during the past two years? Yes / No
   Reason:____
3. Do you take prescription medications? Yes / No
   Details:____
4. Have your Medications changed in the last 6 months? Yes / No
   Details:____
5. Have you experienced any ***allergies/unusual effects*** from any ***tablets, drugs, injections*** or ***anesthetic***? Yes / No
   Details:____
6. Do you carry an ***epipen?*** Yes / No
7. Expecting mothers please let us know how many months ____________________________________ Yes / No
8. Do you smoke? Date you quit smoking:____ Yes / No
9. Have you had any prosthetic surgery? (eg Pacemaker, Heart Valve or Hip Replacement) Yes / No
   Details:____
10. Do you require ***ANTIBIOTIC COVER*** before dental treatment? Yes / No
11. Have you ever had **Botox Treatment** or **Dermal Fillers**? Please Specify: _________________________ Yes / No
12. ***Have you ever had any of the following?*** If so please circle the appropriate.

Rheumatic Fever	Epilepsy	Hepatitis – Specify type A,B,C	Heart Trouble	
Mental Illness	Osteoporosis	Arthritis	Bronchitis	**None**
High Blood Pressure	Diabetes	Gastric Problems	Asthma	
Kidney Trouble	Chest Problems			

Other____

DENTAL HISTORY

1. Approximate date of last dental visit:
   Details:____
2. Have you ever experienced excessive bleeding or bruising from dental treatment? Yes / No
3. Do you become anxious or uncomfortable when you are having dental treatment? Yes / No

How were you Referred: Name of Friend/ Family/ School/ Internet Page etc. ___________________________

SIGNED: Patient / Parent / Guardian __________________________________ Date:____________________

Please note if you fail to attend a scheduled appointment or cancel with less than 24 hours notice we will require a full deposit of treatment before re-scheduling your appointment.