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

Please turn over >

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

Email Form