CAMDEN DENTAL CENTRE
Implant & Cosmetic Dentistry

INFORMATION QUESTIONNAIRE

To help the dentist perform a complete dental examination, the following questionnaire has been formulated. Please answer the questions as accurately as possible. This information will remain confidential. THANK YOU

Mr / Mrs / Miss / Ms / Dr

Surname:_____ First Names: _____

Preferred Name: _____ Date of Birth: ____/____/_____

Home Address: _____ Suburb: _____

Postcode: _____ Phone: Mobile: _____ Work: _____ Home: _____

Email Address: _____

How would you prefer to be contacted for appointment reminders? ☐ Phone ☐ SMS ☐ Email

If Minor, Person Responsible for Account: _____ Relationship: _____

Occupation:_____ Employer: _____

Private Health Fund (if applicable) Name: _____Card #: _____ Position on Card _____

Veterans Affairs Card Holder Gold / White Number: _____

How did you find out about our practice? (Please tick all that apply)

☐ Google. What was your search term? _____ ☐ Sponsorship

☐ Practice Website ☐ Family ☐ Walked past ☐ Magnet

☐ Facebook ☐ Friend ☐ Promotional Advertising ☐ Yellow Pages

☐ Instagram ☐ Signage/Billboard ☐ NSW Health ☐ Health Fund

☐ Other: _____

Emergency Contacts Name: _____ Phone: _____

GP Doctors Name: _____ Phone: _____

Tick any of the following which apply now or had in the past:

Heart Trouble ☐	Asthma ☐	Cancer ☐
High Blood Pressure ☐	Excessive Bleeding ☐	Hepatitis ☐
Heart Murmur ☐	Epilepsy ☐	AIDS or HIV+ ☐
Rheumatic fever ☐	Nervous Disorders ☐	Tuberculosis ☐
Stroke ☐	Radiotherapy ☐	Liver or Kidney disease ☐
Anaemia ☐	Osteoporosis ☐	Sleep Apnoea ☐
Diabetes ☐	Steroid Treatment ☐	Smoker ☐
Arthritis ☐	Joint Replacements ☐	Other: _____

(Women) Are you pregnant now? Yes / No When are you due? _____

State any medicines, pills, or tablets you are taking now (eg pain killers, antibiotics, vitamins, the pill, etc) and the reason

_____

_____

_____

_____

Are you currently receiving any medical treatment? Yes / No Details:_ _____

Have you been hospitalised in the last 12 months? Yes / No Details: _____

Have you ever taken Fosamax/Actonel or Prolia injections or any other osteoporosis medication in the past? Yes / No

Please turn over

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State any allergy or adverse reaction to penicillin, adrenalin, latex or any other drug/medicine: _____

_____

_____

_____

Has your doctor or previous dentist advised you to take antibiotic cover for dental treatment? Yes / No

By signing this form you hereby agree and acknowledge that: (i) you have accurately completed this new patient/medical history form to the best of your knowledge and that failure to make full disclosure may place you in undue medical risk; (ii) you consent to any treatment agreed upon, to be carried out by the dental practitioner and their staff; (iii) you are responsible for payment of all services rendered on your behalf and on behalf of your dependents; (iv) payment is due at the time of service unless other arrangements have been made; (v) an administration or debt collection fee will be added to your account if your account is not settled on the day of treatment; and (vi) your dentist may take images of your face, jaws and teeth both before and after your treatment. These images may be used in a practice portfolio to showcase examples of dental work to other patients (your identity will remain anonymous).

Signature_____ Date _____

Patient Review and Update of Form

At each visit please review this form, note any changes, sign and date in the spaces below:

Signature	Date