Bluff Point Dental

PRIVATE PERSONAL & MEDICAL QUESTIONNAIRE

PRIVATE & CONFIDENTIAL

Welcome to our Practice

Please answer these questions as completely as possible. It will greatly assist us to provide the best dental treatment for you.

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 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.

First Names …….. Last Name …….

Address …….

…… Postcode …….

Date of Birth ……/……/…… Preferred contact: Phone call / Text / Email

Phone (home)…… Phone(work)……Phone (mobile)……

Email ……@……

Occupation …….. Employer ……

Emergency Contact Name …… Phone …… Relationship ……

Person responsible for payment of accounts ……

Private Health Fund (if applicable) …… Member No. …… Patient No. ……

How did you hear about our practice? ……

The state of your health may have a very significant effect on your dental care. Please answer these questions fully or discuss them with your dentist:

	YES	NO
• I have private and confidential medical matters which I wish to discuss with the dentist ……	☐	☐
• Are you receiving any medical treatment at present? ……	☐	☐

- Name of your medical practitioner/specialist ……

Have you ever been in hospital? If yes, nature of hospitalisation and dates:

Nature of hospitalisation	Date

Some medicines may interfere with your dental treatment or react with medicaments used by your dentist. It is important that your dentist knows precisely which medications (if any) that you are taking.

Please list any medications 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 and avoid drug interactions.

If you are in any doubt about your medication, please bring a Pharmacy Medication Summary or the medication packaging to the practice to show the dentist.

Drug name	Dosage	Purpose/condition

Please list any know ALLERGIES or ADVERSE REACTIONS to drugs, (especially antibiotics eg. Penicillin), medicines, antiseptics, local anaesthetics, preservatives, food, chemical or substance that we should know about.

Product name	Nature of Reaction	How long ago

Please tick YES if you have ever had any of the following:

Excessive bruising or bleeding …… ☐

Past serious or infectious disease ☐

……..

Diabetes ☐ Family history of Diabetes ☐

Osteoporosis ☐ Low bone density ☐

Do you receive injections for treatment?..... ☐

High blood pressure ☐ Low blood pressure ☐

Heart condition …….. ☐

Heart Surgery/Pacemaker …….. ☐

Hepatitis, jaundice or liver disease …….. ☐

Kidney/Renal disease …….. ☐

Epilepsy/Seizures …….. ☐

Joint replacement surgery …… ☐

Pain in Jaw ☐ Neck ☐ Shoulder ☐

Thyroid disease Underactive ☐ Overactive ☐

Tuberculosis (TB) …….. ☐

Transplanted organ/bone marrow/stem cells ☐

Asthma ☐ Bronchitis ☐

Lung condition (please specify) ☐

……..

Nervous system disorder …… ☐

Anxiety disorder ☐ Depression ☐

Gastroesophageal reflux disease (GORD) ☐

Treatment for cancer (type/region) …….. ☐

……

Chemotherapy ☐ Radiation therapy ☐

Snoring/Sleep apnoea ……. ☐

Do you have any other illness not listed, or suffer from an infectious disease? **YES / NO** ……

Have you ever smoked **YES / NO** Do you still smoke? **YES / NO** If yes how many? ……/day

If no, Date you quit? **……/……/……**

Have you used recreational drugs or illicit substances? **YES / NO** **Recently / More than 1 year ago**

Please specify which drug **……**

Have you been treated for any smoking related condition **YES / NO**

WOMEN: Are you, or could you be pregnant? **YES / NO** Due date …….

Are you breastfeeding? **YES / NO**

DECLARATION:

In signing this form, I declare that this represents an accurate medical history.
I will advise my Dentist of any changes made to my Medical history, treatment or medications.
I understand that all Medical information will be treated with complete Confidentiality.
I have read the privacy statement provided by Bluff Point Dental.

Patient signature ……. **Date …….**
(Parent/Guardian if under 18 years)

Dentist signature ……. **Date ……..**