CAMDEN
DENTAL CENTRE
*Quality dental care*

# 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: __________________

Date of Birth: __________ Home Address: __________________

Suburb: __________________ Postcode: __________

Phone: Home: __________ Work: __________ Mobile: __________

Email Address: __________________

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

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

Place of Employment: __________________

Address of Employment: __________________

Name of Private Health Fund for Dental Cover (if applicable): __________________

Veterans Affairs Card Holder Yes / No Number: __________________

Who referred you to our practice?

☐ yellow pages ☐ yellowpages.com ☐ magnet ☐ friend/family ☐ google/website ☐ walked past ☐ other_______

Medical Doctors Name: __________________ Suburb: __________

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

| | | | | | |
|---|---|---|---|---|---|
| Heart Trouble | ☐ | Arthritis | ☐ | Blood transfusion | ☐ |
| High Blood Pressure | ☐ | Asthma | ☐ | Hepatitis | ☐ |
| Heart Murmur | ☐ | Excessive Bleeding | ☐ | AIDS or HIV+ | ☐ |
| Rheumatic fever | ☐ | Epilepsy | ☐ | Tuberculosis | ☐ |
| Stroke | ☐ | Radiotherapy | ☐ | Liver disease | ☐ |
| Anaemia | ☐ | Osteoporosis | ☐ | Kidney disease | ☐ |
| Diabetes | ☐ | Taking Bisphosphonates | ☐ | Smoker | ☐ |

Other : __________________

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

__________________

__________________

__________________

__________________

Have you ever taken Fosamax or Actonel in the past? Yes / No If so, when? __________

State any allergy to penicillin, adrenalin or any other medicines: __________________

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

Have you had any complications with extractions or other dental treatment? __________

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

Please state reason for attending our practice __________________

*I understand that the trading policy of this surgery is payment on the day of treatment. An administration charge may be added if I fail to settle my account on the day of treatment. In the event of default, I agree to meet the cost of any debt collection fees incurred.*

Signature__________________ Date __________