

New patient interview form

WE RESPECT YOUR PRIVACY

In order to provide you with the highest standard of dental care, this practice is required to collect personal information from you. This information covers basic details such as your name, address and telephone number, but it is also necessary for us to obtain from you details regarding your general health and past medical or surgical treatments and procedures. Without this general health profile, the treating Dentist or Hygienist is unable to plan your care properly.

Naturally, some of this information is of a personal nature, some of it may be regarded as 'sensitive' and not the sort of information you would wish to be unnecessarily disclosed to others.

We value the need to safeguard this information and in accordance with the principles laid down in privacy legislation and the guidelines issued by the Australian Dental Association, we would like to assure you that:

- This information will only be used by the treating Dentist or Hygienist in order to deliver your care to the highest standards
- It will not be disclosed to those not associated with your treatment without your expressed consent
- You may seek access to the information held about you and we provide this access without undue delay. This access might be by inspection of your dental records at the time of your appointment or by special access or copying of information at other times
- There will be no charge made for requesting this information but there may be fees levied just to cover the costs associated with the processing of this request or the copying of information.
- We will take reasonable steps to ensure at all times that the details we keep about you are accurate, complete and up-to-date
- We will take all reasonable steps to protect this information from misuse or loss and from unauthorised access, modification or disclosure
- Our staff are trained to respect these principles at all times

If you have any questions regarding the information we collect from you and hold in your dental records, please do not hesitate to ask us. We are acting in your interests at all times.

Prof Dr Fr Mr Mrs Ms Miss Master

Full Name _____

Address _____

Home phone _____

Work phone _____

Mobile phone _____

Email _____

Date of birth _____

Occupation _____

Employer _____

Health insurance _____

Contact person in case of emergency _____

Who referred you to our office? _____

Person responsible for dental investment _____

When was your last dental visit? _____

Why did you leave your last dentist? _____

What has been your concern with previous dental visits? _____

What is your main dental concern today? _____

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Are your teeth sensitive to:

- | | |
|------|-----------------|
| Heat | Sweet |
| Cold | Biting pressure |

Does food catch between your teeth? _____

Do your gums bleed when brushing or flossing? _____

Do you notice an unpleasant taste or odour in your mouth? _____

Have you had any complications during or following dental treatment? _____

Have you had prolonged bleeding after tooth removal or dental surgery? _____

Is there anything you would like to change about your teeth or their appearance? _____

Do you grind your teeth or clench your jaws? _____

Have your jaw muscles ever been sore? Yes or No

Please describe how you feel about dental treatment by putting an X on this line

Pleasant _____ 0 _____ Terrible

Are you being treated for a medical condition? _____

Who is your doctor? _____

Are you taking any medications or supplements at present, both prescribed or over the counter?

(Please list) _____

Do you have, or have you ever had, any of the following medical conditions?

- | | | |
|---|--|--|
| <input type="checkbox"/> Steroid therapy | <input type="checkbox"/> Stomach or digestive condition (reflux) | <input type="checkbox"/> Excess bleeding |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Leukaemia, cancer | <input type="checkbox"/> Hepatitis or liver disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous condition | <input type="checkbox"/> Contact with HIV/AIDS virus |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anaemia or blood disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Prosthetic implant eg. |
| <input type="checkbox"/> Heart valve disorder | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Prosthetic hip or knee |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Bronchitis, emphysema or other lung disease |
| <input type="checkbox"/> Radiation or chemotherapy | <input type="checkbox"/> Transported organ or bone marrow | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Cardiac pacemaker | _____ |
| <input type="checkbox"/> Heart complaint or heart surgery | | _____ |
| <input type="checkbox"/> Eating disorder | | _____ |

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Please list all known allergies _____

Do you smoke? _____

For females, are you pregnant or undergoing fertility treatment? _____

Your signature: _____ Date: _____