ORACLE DENTAL

Suite E317
3 Oracle Boulevarde
Broadbeach 4218

CONFIDENTIAL PATIENT QUESTIONNAIRE

It is important to know details about your medical history as these could affect the success of your dental treatment and how we can provide this treatment safely for you.

Name: _____
Surname First Names Dr / Mr / Mrs / Miss / Ms

Home Address: _____ Work Address: _____

_____ _____

_____ _____

Home Phone: _____ Occupation: _____

Work Phone: _____ Date of Birth: _____

Mobile Phone: _____ Health Fund _____

Email: _____ ☐ Please tick if you would like to receive our quarterly newsletter by email

Details of person to contact in an emergency:

Name: _____ Phone Number: _____

Medical Doctors Name: _____ Phone (If known): _____

MEDICAL HISTORY

1. Do you normally require antibiotic cover before treatment? No Yes
2. Have you had any abnormal reaction to local or general anaesthesia? No Yes
3. Are you being treated by doctor at present? No Yes
4. Women, are you pregnant? If so, how many months: _____ No Yes
5. Have you been hospitalised in the last 12 months? No Yes
6. Are you taking any prescription or other medications at present? If so please list below. No Yes

_____

7. Please list any known allergies (including drugs, latex, food & preservatives.) _____
8. Have you ever had any of the following? **Please tick yes or no for each condition**.

	No	Yes		No	Yes		No	Yes
Steroid therapy			Excessive bleeding			Prosthetic implants		
Rheumatic fever			Stroke			eg artificial hip/knee		
Epilepsy			Cancer			Lung conditions		
Asthma			Tuberculosis			Hepatitis or other liver		
Diabetes			Thyroid disease			diseases		
Bone disease, including osteoporosis			Nervous or psychiatric condition			Exposure to blood-borne viruses eg HIV		
Heart disorder			High/low blood pressure			Anaemia, leukaemia or		
Radiation therapy			Cardiac pacemaker			other blood diseases		
Kidney disease			Stomach disorders			Do you smoke?		

Any other condition(s) not mentioned please list:_____

DENTAL HISTORY

1. Approximate date & details of last dental visit: _____
2. Do you have Dental pain or a Dental problem at present? Yes / No
   Details: _____
3. Do you become anxious or uncomfortable when you are having dental treatment? Yes / No

How did you find us?

☐ Yellow pages online ☐ Internet search ☐ Referred by: _____

☐ Yellow pages book ☐ Work in Oracle complex ☐ Other: _____

Signed: Patient/Parent/Guardian _____ Date: _____

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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 the dentists to obtain from you details regarding your general health and past medical or surgical events. Without this general health picture, the treating dentist is unable to plan your care properly.

Naturally, some of this information is of a personal nature and some of it might be regarded as 'sensitive' and not the sort of information that 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 in order to deliver your care to the highest standards.
- It will not be disclosed to those not associated with your treatment without your consent except as provided under the legislation and where we consider you would have a reasonable expectation of us to provide such information.
- You may seek access to the information held about you and we will provide this access without undue delay. This access might be by inspection of your dental records at the time of appointment or by special access or by copying of information at other times.
- 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 reasonable steps to protect this information from misuse or loss and from unauthorized 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 time

Patient Signature_____Date_____