Dental Patient Questionnaire

Title Dr / Mr / Mrs / Miss / Ms
Date of Birth _____
First Name _____ **Last Name** _____
Occupation _____ **Ethnicity** _____
Address _____ **Home Phone** _____
_____ **Mobile** _____
NHI Number _____ **Email Address** _____

How did you hear about us?
◯ Sign / Building Location ◯ Word of Mouth ◯ Radio / Newspaper
◯ Existing Fono Medical Patient ◯ Social Workers ◯ Other _____
◯ Google / Internet / Facebook (circle one please)

Are you currently receiving a WINZ benefit? ◯ Yes ◯ No
Do you have a Community Services Card? ◯ Yes ◯ No
Are you a smoker? ◯ Current ◯ Former ◯ Never

Name of your General Practitioner (GP) / Practice Name _____

Please tick any of the following medical conditions that apply to you

◯ Heart Murmur	◯ Asthma	◯ Sinus / Hay Fever	◯ Gastric Problems
◯ Heart Surgery	◯ Chest / Lung Disease	◯ Epilepsy	◯ Liver Problems
◯ Rheumatic Fever	◯ Excessive bleeding	◯ Diabetes	◯ Kidney Problems
◯ High Blood Pressure	◯ Stroke	◯ HIV / Hepatitis B or C	◯ Osteoporosis
◯ High Cholesterol	◯ Psychiatric Illness	◯ Prosthetic Joint	◯ Pregnant (Weeks_____)
◯ Cancer	◯ Radiotherapy	◯ Chemotherapy	◯ Other _____

Please list any medications you are taking: _____

Please list any allergies you have to any medicine or other substances e.g. latex, antibiotics etc.

_____

Blood Tests Although rare, accidental injury to you or staff can occur during handling of instruments. Should this happen, our practice requires both parties to undertake blood tests. Do you agree to a confidential blood test?
◯ Yes ◯ No ◯ I wish to discuss with the dentist

Clinical Records All photographic / radiographic images and clinical records can be released to you or a third party with your written / verbal consent.

Cancellation You accept paying a fee of $25 per 30 minutes for failing to attend an appointment or for failing to provide 24 hours' notice for cancellation.

Payment Payment for treatment is expected on the day of the appointment. Arrangements can be agreed in advance through written application for variations to the payment terms. Treatment may be withheld if payment is not made and any outstanding amount due will be passed to a collection agency.
What is your preferred payment method?
◯ EFTPOS ◯ Credit Card ◯ Cash ◯ Automatic Payment

Contact My mobile number and email address will be used as a means to communicate with me. Tick here if you **do not** wish for us to use your contact details ◯

Newsletter Would you like to subscribe to The Fono's digital newsletter? ◯ Yes ◯ No

Consent I consent to the dental treatment recommended by my dentist. The planned procedure will be advised with consultation and discussion with my dentist regarding the cost, pros, cons and potential risks involved.

Signature of Patient / Caregiver _____ **Date** _____