PRESTON DENTAL GROUP
Holistic Dental Care

# *Welcome to our practice*

Thank you for choosing us – we look forward to providing you and your family with gentle, comfortable, high-quality dental care.

We aim to help all of our patients achieve the dental health they need and want – *for life*.

Our highly trained team uses the best techniques, instruments and materials.

More importantly, we take the time to find out about people's dental problems and needs – our check-ups are quite thorough and we spend a lot of time **listening** to you. This is the basis of what we call our holistic approach to dental care, which recognizes the links between your mouth and your overall health.

We also want to make sure you get the care you actually want. We aren't happy until you understand everything we discuss with you, are comfortable with your treatment choices, and are happy with your actual treatment.

And we're ***GENTLE***.

Finally, to make life a little easier for you we offer **flexible** opening times, a range of **payment options** (including EFTPOS and credit card), easy **carparking** – we even have coffee & tea to make sure you are comfortable.

## Welcome to Preston Dental Group – we look forward to helping keep your smile in great shape!

***PS*** please fill in the attached Health Questionnaire and bring it with you to your appointment. Please come **5 minutes early** to allow us to put your information on our computer system. Thank you!

PRESTON DENTAL GROUP

# HEALTH QUESTIONNAIRE

*all information you give is kept private & confidential*

**For Office Use**
☐ scanned
☐ seen by dentist
dentist's initials:

**Your name:** Mrs / Miss / Ms / Mr ..... SURNAME ..... FIRST NAMES

Your preferred name ..... **DATE OF BIRTH** .....

**Occupation** ..... do you have **Dental Insurance?** .....

**Home Address** ..... STREET ..... SUBURB ..... POSTCODE

**Email** ..... ID number (driver's license, Medicare etc) .....

**Phone:** Home ( ) ..... Work ( ) ..... Mobile .....

Next of kin (eg parent, spouse) ..... Person responsible for payment .....

To ensure our treatment is matched to your present state of health, please answer these questions

**Your medical doctor's name:** ..... Doctor's phone number: .....

Have you had any of the following health problems? (please **TICK** boxes ☑ for 'YES' or 'NO' **)**

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | I am receiving medical treatment | ☐ | ☐ | Ladies - are you pregnant? Month Due: ..... | | | |
| ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | Hepatitis type A / B / C | ☐ | ☐ | Epilepsy / Fits |
| ☐ | ☐ | Artificial joint or heart valve | ☐ | ☐ | Diabetes | ☐ | ☐ | Nervous problem |
| ☐ | ☐ | Any Heart Problem | ☐ | ☐ | Do you bruise easily? | ☐ | ☐ | Cancer |
| ☐ | ☐ | Blood Pressure: HIGH / LOW | ☐ | ☐ | Asthma | ☐ | ☐ | Arthritis |
| ☐ | ☐ | Heart Surgery | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Glaucoma |
| ☐ | ☐ | Stroke | ☐ | ☐ | Thyroid condition | ☐ | ☐ | Digestive problems |
| ☐ | ☐ | AIDS/HIV | ☐ | ☐ | Easy bleeding / anaemia | ☐ | ☐ | Had any operations? |
| ☐ | ☐ | Do you use addictive drugs? | ☐ | ☐ | **Do you smoke cigarettes?** **How many per day?** ..... | | | |
| ☐ | ☐ | I have private medical information which I do not wish to write down | ☐ | ☐ | **I prefer to speak to the Dentist in private about this** | | | |

☐ ☐ Have you had allergies / reactions to Penicillin, anaesthetic or other substances? (please write down which ones)
.....

**Please list any medicines or tablets you are taking:** .....

.....

What is the reason for your visit today? ☐ Toothache Or Pain ☐ Broken Tooth / Lost Filling ☐ Check-Up

☐ Other reason: .....

**Who recommended us to you?** ..... **How long since you saw a dentist?** .....

What would you like to change about your smile? .....

Do you clench / grind your teeth at night or during the day? ☐ Yes ☐ No

**PLEASE NOTE:** FEES ARE APPLICABLE IF APPOINTMENTS ARE CANCELLED WITH LESS THAN 24 HOURS NOTICE. A processing fee is charged when handling requests to release patient records to other practitioners.

***THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE***

**Signature** (Parent or Guardian if under 18 years) ..... **Date** .....



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