DR ROCCO ARENA

& ASSOCIATES

Personal Details

CONFIDENTIAL PATIENT QUESTIONNAIRE

Mr. / Mrs. /Miss. /Ms. /Dr ....
First Name/s Surname

Parents name (if under 21) ....Date of Birth ..../......../...........

Address: .... Post Code ....

Phone: Home....................................... Mobile .... Work ....

Email Address ....@................................. Occupation....................................

What is your preference for communication from our practice?

Home phone □ Workplace □ Mobile □ SMS □ Email □

Family Doctor Name .... Phone No. ....

Name of health fund .... Are you covered for dental? YES / NO

Is this a Work Cover or insurance claim? YES / NO MEDICARE NUMBER. ....

How were you recommended to this surgery? (E.g. Friend ,Family, Website, Health Fund, Live Nearby, Yellow pages)

Family member/Friend (if so, who?) .... Other ....

Medical and Dental History

How long since you last visited a dentist? ....Have you had dental x-rays in the past 2 years? YES / NO.

Is there anything that bothers you about your teeth ? e.g: bad breath, appearance, bleeding when brushing, loose teeth

....

Do you consider your general health to be good? YES / NO

Are you being treated for any condition by your doctor now? YES / NO

Have you ever had an allergic reaction to any medication (i.e.; Penicillin) YES / NO

If yes please list ....

SMOKING Do you or have you ever smoked? YES / NO

Women – are you; Pregnant, Nursing or do you think you may be pregnant? YES / NO

STRESS Have you had any major life changes recently? YES / NO Do you sleep well? YES / NO

Are you taking any medications, herbal medications or over the counter drugs or pills?

If **YES**, please list ....

In particular are you taking medication affecting calcium and bone metabolism?

(i.e.: Fosamax, Actonel, Aredia, Bonefos, Didrocal, Pamidronate, Pamisol? YES / NO

Do you have or have you ever had any of the following conditions? (please tick if YES and specify)

	YES	NO		YES	NO
Rheumatic fever	□	□	Liver problems	□	□
Heart murmur	□	□	Diabetes	□	□
Artificial heart valve	□	□	Family history of diabetes	□	□
Congenital heart disease	□	□	Thyroid problems	□	□
Mitral valve prolapsed	□	□	Kidney / bladder trouble	□	□
Pacemaker	□	□	Stomach ulcers	□	□
High blood pressure	□	□	Epilepsy or seizures	□	□
Heart disease / heart attack	□	□	Psychiatric treatment	□	□
Stroke	□	□	Nervous/anxiety	□	□
Artificial joint (hip, knee etc)	□	□	Neurological disorders	□	□
Haemophilia	□	□	Fainting / dizzy spells	□	□
Anaemia	□	□	Frequent headaches	□	□
Bleeding problems	□	□	Cortisone / steroids	□	□
Bruise easily	□	□	Arthritis / rheumatism	□	□
Blood transfusion	□	□	Asthma	□	□
Tumors	□	□	Emphysema	□	□
Chemotherapy	□	□	Sinus troubles	□	□
Radiotherapy	□	□	Glaucoma	□	□
HIV	□	□	Latex sensitivity	□	□
Hepatitis A, B or C	□	□	Metal Allergies (i.e. Nickel)	□	□
Cold sores / fever blisters	□	□	Injury to face or jaw	□	□

Please list any disease, condition or problem not listed ....

- I understand the above information is necessary to provide me with dental care in a safe manner.
- I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information.
- I will notify the dentist / hygienist of any changes in my health or medication.
- I agree that I will pay my account on the day of my treatment unless pre-arranged with the dentist in which a formal financial arrangement must be formulated.
- I agree to pay all legal and debt collector's costs and expenses incurred by you in attempting to recover any overdue amounts.

I understand that Arena Dental under the Privacy Act 2002 (SA) are committed to protecting your privacy with regards to all information collected in person, by phone, email or any other means. For full details of our Privacy Policy please ask our staff.

Patient / Guardian Signature .... Date ..../......./.............