INTEGRATED DENTISTRY

Welcome to our modern practice. Here at Integrated Dentistry, we strive to offer the best of dental and chiropractic care and hope to achieve a positive experience for all concerned. We ask that you complete all of the details and answer all of the questions on the following pages carefully and accurately, before your initial examination.

Patient Questionnaire

Reason for visit _____

General Information

Dr, Mr, Mrs, Miss _____ Birthdate ____ /____ /____
Last First Middle Day / Mth / Year

Home Address _____ Phone (___) _____
Number Street

_____ Mobile _____
Suburb City / State Postcode

If less than one year, previous address _____

Email address _____ Occupation _____

Employer _____ Phone (___) _____

Marital Status _____ Name of Spouse _____

Person responsible for account _____

Whom may we thank for referring you? _____

Medical History

Name of Doctor _____

City/Suburb _____ Phone (___) _____

If you have a current medical problem, please give details _____

_____

Please tick if you have now or have ever had any of the following –

- ☐ Heart Disorder
- ☐ Pacemaker/cardiac surgery
- ☐ Blood Pressure
- ☐ Other blood or bleeding disorder
- ☐ Stroke
- ☐ Rheumatic Fever
- ☐ Asthma/Bronchitis
- ☐ Other Lung Problems
- ☐ Do you smoke
- ☐ Nervous or emotional disorder or therapy
- ☐ Epilepsy or Fainting spells
- ☐ Other neurological disorder
- ☐ Thyroid Disorder
- ☐ Diabetes – Type I or II
- ☐ Family history of Diabetes
- ☐ Ulcer or Hiatus Hernia
- ☐ Hepatitis B or C
- ☐ HIV positive
- ☐ HIV / AIDS related diseases
- ☐ Radiotherapy or Chemotherapy
- ☐ Arthritis or sore joints
- ☐ Insomnia
- ☐ Migraine
- ☐ Tension Headaches
- ☐ Snoring / Sleep Apnoea

Please tick if you are now –

- ☐ Pregnant
- ☐ On a Prescribed diet
- ☐ Using anticoagulants or blood thinners
- ☐ Using Thyroid Medication

Tick if you are now taking medication for –

- ☐ Heart or Blood Pressure
- ☐ Blood Disorders
- ☐ Cholesterol
- ☐ Lung disorders
- ☐ Gastrointestinal problems
- ☐ Diabetes
- ☐ Nervous disorders (eg depression)
- ☐ Sleeping
- ☐ Arthritis
- ☐ Headaches

Tick if you are allergic to, or made sick by –

- ☐ Penicillin
- ☐ Other antibiotics
- ☐ Iodine
- ☐ Codeine
- ☐ Aspirin
- ☐ Other Medication (Please specify)

_____

Please tick Yes or No *If yes, please specify*

Y ☐ N ☐ Do you have any other allergies? _____

Y ☐ N ☐ Do you have any physical disabilities? _____

Y ☐ N ☐ Have you had a major operation? _____

Y ☐ N ☐ Have you been hospitalised for any reason? _____

Y ☐ N ☐ Have you been involved in a serious accident? _____

When was your last medical examination? _____
Month *Year*

Dental History

Why did you seek dental care at this time? _____

When was your last dental examination? _____
Month *Year*

Please tick Yes or No

Y ☐ N ☐ Were X-rays taken at that time?

Y ☐ N ☐ Are you self-conscious about your teeth?

Y ☐ N ☐ Have you had orthodontic treatment (braces or plates)?

Y ☐ N ☐ Is any part of your mouth sensitive to hot / cold / sweets?

Y ☐ N ☐ Is any part of your mouth sensitive to pressure?

Y ☐ N ☐ Do you have pain or soreness around the eyes or ears?

Y ☐ N ☐ Do your jaw joints hurt or make noises?

Y ☐ N ☐ Do you have an unpleasant taste or odour from your mouth?

Y ☐ N ☐ Do your gums bleed or feel tender?

Y ☐ N ☐ Do you use Floss regularly?

Y ☐ N ☐ Have you ever had professional instruction on how to clean your teeth?

Y ☐ N ☐ Do you believe that you will lose your teeth and eventually have to wear full dentures?

Y ☐ N ☐ Do you want to learn to control dental disease and retain your teeth?

I have accurately completed this Preclinical Examination Questionnaire to the best of my knowledge. I hereby authorise the professionals and their staff at Integrated Dentistry to render any treatment agreed upon and I assume full financial responsibility for said treatment.

Signed by _____ Date _____
(parent or guardian if patient is a minor)

Checked by _____