Channon Lawrence Dental
Address: 90 Channon Street
Gympie, QLD 4570
Phone: (07) 5482 7688
Email: admin@channonlawrencedental.com.au

Date:

New Patient Medical Questionaire

Information provided is completely confidential and is protected by the provisions of the Federal Privacy Law Legislation. Your assistance in completing our acquaintance form assists us to provide you with dental care of the highest standard.

Title:

First Name: Last Name:

Preferred Name:

Home Phone: Mobile:

Business Phone: Email:

Preferred method of contact?:

Occuptation: Employer:

Next of Kin: Relationship:

Next of Kind phone:

Private Dental Insurer:

Medicare Number: # On Card:

Medicare Expiry Date:

Referred from:
Billboard ☐ Google ☐ White Pages ☐ Existing Patients ☐ TV ☐ Welcome Connect ☐
Social Media ☐ The Gympie Times ☐ Rainbow Beach News ☐ Other

Are there any matters of a confidential nature you wish to discuss in private?

Medical History: Please tick relevant

Heart disease ☐	Hepatitis A,B or C ☐	Asthma ☐
High blood pressure ☐	Diabetes ☐	Epilepsy ☐
Low blodd pressure ☐	Liver disease ☐	HIV/AIDS ☐
Other blood disorder ☐	Serious illness ☐	Hospitalised in last 2 years ☐
Stroke ☐	Hyperthyroidism ☐	Kidney disease ☐
Cancer ☐	Nervous disorders ☐	Neck or back problems ☐
Allergy to medications ☐	Allergy to latex ☐	Smoker ☐

Do you use a CPAP Breathing Device? ☐ Allergies:

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Do you require antibiotic therapy for any condition prior to undergoing dental treatment?
ie; heart murmur or artificial hips/knees

Are you currently taking medication to treat osteoporosis ? ☐

Possibility of pregnancy? ☐

Have you recently experienced cold/flu symptoms? ☐

Current medications and/or vitamins?

Name and contact of your Medical Practioner or clinic:

Dental History:

Is there anything in particular you wish to discuss with us today regarding your teeth?
If yes, details

Have you had problems with previous dental visits (e.g. with anaesthetic, etc)?
If yes, what was your previous experience?

Do you wear a partial or full denture? If so, how long have you worn your denture?

How many times do you brush your teeth per day?

Do you floss? If yes, how often?

Does any of the following apply to you and your teeth? (tick all applicable)

Floss catches or shreds ☐
Do you play contact sport ☐
Gums bleed when brushing/flossing ☐
Do you have worn, chipped or jagged edges that bother you ☐
Have you been diagnosed with Periodontal Disease ☐
Do you have old fillings or other dental work that causes discomfort? ☐
Do you have spaces or gaps that bother you ☐
Do you like the colour of your teeth ☐
Do you grind your teeth ☐
How would you rate your smile 1 to 10 ☐
Does your jaw click ☐
Do you wake with sore/tired jaw ☐
Are you a mouth breather ☐

How would you improve your smile? (Colour, shape, length etc).

I understand that I am personally responsible for all dental services rendered.
I acknowledge that payment is appreciated and expected on the day of treatment, unless prior arrangements have been made.

Signed: Date:

NB: Patients under the age of 18 years must have this form signed by a Parent or Guardian.
Thank-you for assisting us in providing you with the highest level of care.