east adelaide
dental studio
YOUR HEALTH YOUR SMILE

New Patient Questionnaire

Dr. Mr. Mrs. Ms. Miss. Master. (Full Name): _____

Address _____ Post Code _____

Date of Birth _____/_____/_____ Occupation _____

Home Ph _____ Work Ph _____ Mobile _____

Email _____

Name and Address of workplace _____
Name of Dental Health Fund _____
Person Responsible for Account _____
Who can we thank for recommending you to us? _____

Medical History

Name of Family Doctor _____
Are you taking any medications or supplements at present? _____
Do you have, or have you ever had, any of the following medical conditions? Please Tick.

- ☐ Allergies (Specify) _____ _____
- ☐ Asthma
- ☐ Cardiac Pacemaker
- ☐ Diabetes/ Epilepsy
- ☐ Excessive Bleeding
- ☐ Heart complaints or heart surgery
- ☐ Hepatitis A, B or C
- ☐ High/Low blood pressure
- ☐ Kidney Disease
- ☐ Pregnant/Fertility Treatment
- ☐ Smoker, How many per day?
- ☐ Prosthetic implants
- ☐ Other: _____ _____

Dental History

When was your last dental visit? _____
What is your main dental concern today? _____
Do you expect to keep all or most of your teeth for the rest of your life? _____
Are you dissatisfied with your teeth and their appearance? _____
Have you been made aware of clenching or grinding your teeth during sleep? _____
Do you have frequent headaches or neck and shoulder pain? _____

All accounts are to be settled at the end of each appointment.

☐ Cash Credit ☐ Card/Eftpos ☐ Cheque

East Adelaide Dental Studio values our patients time, we strive to honour the appointment times we make with you. However because of complications we may run 5-10mins late. Should you not be able to keep the appointment reserved for you, we expect 24 hours notice of cancellation otherwise a non attendance fee may result.

_____ / /
Patient Signature Date