**Personal Details**

Title **(Please circle)** DR MR MRS MS MISS MASTER

First name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suburb\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_Postcode\_\_\_\_\_\_\_\_

Phone Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of General Medical Practitioner (GP)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GP’S phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Clinic\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

Next of Kin\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have private health insurance with dental extras? If yes, which one?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? Google Facebook Walked past Friend or family (if so, who?)

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

*We request payment at the time of treatment – no accounts are given. For your convenience we accept on the spot Health Fund claims with HICAPS (health fund card required), cash, EFTPOS facilities (including Visa, Mastercard and Amex).*

*If there is anything you wish to discuss privately with the dentist, please tick this box.*

**Medical Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Please indicate if you have or have ever had any of the following** | **Yes** | **No** | **Additional notes** |
| Heart Problems (including valve problems or pacemaker) |  |  |  |
| Rheumatic fever |  |  |  |
| High/Low blood pressure |  |  |  |
| Bleeding disorders/conditions |  |  |  |
| Do you require antibiotic cover for dental treatment? |  |  |  |
| Hepatitis |  |  |  |
| Contact with HIV/AIDs |  |  |  |
| Are you currently on medications? Please list |  |  |  |
| Tumour or Cancer requiring radiation or chemotherapy |  |  |  |
| Osteoporosis requiring medication |  |  |  |
| Steroid therapy |  |  |  |
| Epilepsy |  |  |  |
| Asthma |  |  |  |
| Do you smoke? |  |  |  |
| Are you pregnant? |  |  |  |
| Thyroid disease |  |  |  |
| Mental illness |  |  |  |
| Known allergies, please list |  |  |  |
| Diabetes (type) |  |  |  |
| Liver or Kidney problems |  |  |  |
| Anaemia |  |  |  |

**COVID DECLARATION**

Have you been overseas in the last 14 days or been in contact with anyone known to have COVID-19 or currently in isolation for COVID-19 or awaiting test results? **YES/NO**

Do you have any COVID-19 symptoms: (fever, dry cough, tiredness, sore throat, aches and pains, headache, loss of taste/smell, rash on skin or discolouration of fingers or toes, diarrhoea, conjunctivitis, difficulty breathing/shortness of breath, chest pain or pressure, loss of speech or movement? **YES/NO**

Have you been to one of the contact tracing venues listed on Queensland Health during the period specified as being at risk of infection? **YES/NO**

I have filled out this questionnaire to the best of my knowledge and hereby give authority for any treatment agreed upon by me to be carried out but the dentist and their staff. I assume full financial responsibility for said treatment.

Patient/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_