INFORMATION QUESTIONNAIRE

To help the dentist perform a complete dental examination, the following questionnaire has been formulated.
Please answer the questions as accurately as possible. This information will be held confidential. *Thank You*

Mr / Mrs / Miss / Ms / DR ……Date of Birth ……..…..
SURNAME GIVEN NAMES

Home/Postal Address ……

Home Phone……Mobile Phone……..
Your Email Address……..
Parent / Guardian …… Phone……..
Occupation……
Health Fund or Dental Cover (if any)……Membership No……Ref No……..
Emergency contact Name…….. Phone…… Relationship……

PLEASE ANSWER EACH OF THE FOLLOWING

1. Medical Practitioner's name……..
2. State any medications you are taking –especially Hormone Replacement Therapy or Fosamax.
   ……..
3. State any allergy to penicillin, iodine, adrenalin, or any other medicine.
   ……
4. Have you had any operations/surgery? If yes – What was the procedure? When was the procedure preformed?
   ……
5. Tick any of the following which you have had:

   ☐ Heart Trouble ☐ Asthma ☐ Stroke ☐ High Blood Pressure ☐ Hepatitis A B C (Please Circle)

   ☐ Diabetes ☐ Epilepsy ☐ Anaemia ☐ Tuberculosis ☐ Cancer Treatment/Radiotherapy

   ☐ Rheumatic Fever ☐ Arthritis Other……..…
6. Do you have a medical condition which requires Antibiotics prior to Dental Treatment (E.g. Joint Replacement / Hip Replacement)? Yes / No
7. Do you smoke? Yes / No - If yes, how many a day? …… How long Have you smoked for? ……
8. WOMEN: Are you pregnant now? ..... Due Date……..
9. Have you ever had Abnormal reaction to any of the anaesthetics or excessive bleeding during dental treatment? Yes / No
10. **Are you interested in Teeth Whitening?** Yes / No **Do you or anyone that you know suffer from snoring or disturbed sleep?** Yes / No
11. How would you like to be reminded of your appointment? SMS Phone call Email

SURVEY QUESTIONNAIRE – *How did you find out about us?*

Please tick one of the boxes listed below on how you selected Swansea Dental Care for you dental treatment: By providing the name of the person who Referred you, we will be able to send them a Thank You card for gratitude of their support.

☐ Yellow/ White Pages ☐ Local Directories ☐ Google Search Engine ☐ Live Locally ☐Facebook

☐ School Newsletter ☐ White Pages ☐ Government Clinic ☐ Friend / Family Name:…….

☐ Radio Ad ☐ Business Website ☐Walked Past ☐ The Pelican Itch

Privacy & Financial Agreement

I (name)_____consent to the below statement.

Payment on the day of treatment is required. Any expenses, costs or disbursements incurred by Dentist for Chickens in recovering any outstanding Monies including debt collection & solicitor fees shall be paid by the responsible party named above. I further acknowledge that failure to attend Appointments without giving notice may incur a broken appointment fee which is payable by the above mentioned party.

I consent to the collection, use, disclosure and handling of my personal information and to use of my telephone number in accordance with Privacy Notice. Our privacy policy is available at www.dentistforchickens.com.au . Alternatively, please ask us for a copy at the office.

Signature…… **Date/ Updated:** ……