PRECLINICAL QUESTIONNAIRE

Dental Care @ Berri

healthy smile = healthier life

Welcome to Dental Care @ Berri. We appreciate the confidence you have placed in us to provide your dental care. To assist us with providing you with the best possible care, please complete the following details.

YOUR DETAILS

Full Name:_____

Title First Name Middle Name Surname

Preferred Name:_____ Birth Date:_____

Postal Address: _____

Residential Address: _____

Telephone: Home _____ Work_____

Mobile_____ Email_____

Preferred method of contact *(please circle):* SMS Phone Email

Preferred contact number_____

Occupation:_____ Employer_____

Emergency Contact Name_____ Phone_____

PAYMENT INFORMATION

Person responsible for payment on the day of treatment (if not self)_____

If you have any other family members attending our practice would you like your accounts linked?

☐Yes ☐No If yes who? _____

Veteran Affairs ☐Gold ☐White Card Number _____

Private Health Fund _____ Line Number _____

HOW DID YOU FIND OUT ABOUT DENTAL CARE @ BERRI

☐Yellow Pages ☐Yellow pages online ☐Facebook ☐Internet ☐Practice Website ☐Passing by

Referred by staff who? _____ By another patient who?_____

MEDICAL AND DENTAL HISTORY

How do you rate your general health? ☐ Excellent ☐Good ☐Poor ☐Fair

Name of your doctor or medical clinic_____

Are you allergic to anything eg local anaesthetic, latex, penicillin, peanut etc.?

_____

What medications including natural remedies are you taking?

_____

_____

Have you had any of the following?

	Y	N		Y	N
Rheumatic fever	☐	☐	Artificial joints	☐	☐
Excessive bleeding or bruising	☐	☐	Anaemia or Blood Disorders	☐	☐
Pacemaker	☐	☐	Diabetes	☐	☐
Blood pressure	☐	☐	Asthma	☐	☐
Heart Problems	☐	☐	Reflux	☐	☐
Osteoporosis	☐	☐	Sinus trouble	☐	☐
Cancer History	☐	☐	Hearing Aid	☐	☐
Epilepsy	☐	☐	Hepatitis	☐	☐
Liver or Kidney Problems	☐	☐	HIV	☐	☐
Are you pregnant or breasfeeding	☐	☐			

How long is it since your last dental appointment? _____

Previous dental radiographs last taken: ☐Less than 1 year ☐Longer than 1 year

Please tick any dental concerns that you have:

☐Toothache	☐Missing teeth	☐Pain in face or jaw joints	☐Sensitive teeth
☐Unsatisfactory denture	☐Sounds from joints	☐Bleeding gums	☐Rapidly decaying teeth
☐Difficulty chewing	☐Loose teeth	☐Lost filling/cavity	☐Discoloured teeth
☐Bad Breath	☐Grinding/clenching	☐Dry mouth	☐Worn, broken teeth
☐Bad appearance of teeth	☐Do you, or have you ever smoked		

Please tick if you have had any of the following dental treatment:

☐Orthodontics (braces) ☐Dental night guard ☐Root canal treatment ☐Periodontal (gum) treatment

Is there anything else you would like us to know? _____

CONSENT

I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentists and their staff and I assume full financial responsibility for said treatment. I understand that payment is due at the time of the service unless prior arrangements have been made.
Due to Privacy and Confidentiality laws, we are prohibited from disclosing any information regarding your personal details and/or dental treatment unless you have personally signed a request form.
A cancellation fee may apply if less than 48 hours notice is given.

Your signature: _____ Date: _____

(Parent or Guardian to sign if patient is a minor)

WE ACCECPT ALL MAJOR CREDIT CARDS, PERSONAL CHEQUE, EFTPOS AND CASH

HICAPS FACILITIES ARE AVAILABLE

24 Wilson Street BERRI SA 5343 P 08 8582 5566 F 08 8582 5560

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