

First name: (Ms, Miss, Mrs, Mr, Master, Dr, Prof)	Surname:
DOB:	Address: Suburb:
Mobile:	Home/work phone:
Email:	Occupation:
Who can we thank for referring you:	Dental Health Fund:

What is your cultural background? _____

Do you Require an interpreter Yea No

Are you receiving any medical treatment at this present time? Yes No

Please list all your medications taken: _____

Have you experienced any allergies or unusual effects from any tablets, injections or anaesthetic? Yes No

Details: _____

Do you require antibiotic prophylaxis before dental treatment? Yes No

Have you ever had any of the following? Please Tick

	3		3
Heart Problems		Anaemia or other blood disorders	
Blood Pressure		Diabetes	
Artificial joints		Asthma	
Rheumatic Fever		Hepatitis A B C D E (Please specify)	
Circulatory problems		Epilepsy	
Radiation Treatment		Liver problems	
Excessive bleeding		Kidney problems	
Excessive bruising		Sinus trouble	
Ulcers (stomach)		Cancers/Tumours	
Are you pregnant? (Women)			

Details of person to contact in an emergency:

Name: _____ Relationship: _____ Phone No: _____

Name of your GP: _____ Phone No: _____

Dental History

To enable the dentist to provide care specific to your individual needs, we would very much appreciate the following information:

Name and location of last dentist? _____

Approximate date of last dental visit? _____

Please circle:

Do you become *anxious* or *uncomfortable* when you are having dental treatment? Yes No

Are you a smoker? Yes No

Do you have teeth missing? If so, how many? _____

Do you have: Implants Dentures Crowns Bridges

Fillings 0 <10 <20 20+

Have you had any other specialist? Perio Endo Ortho Oral surgery
treatment in the past?

Do you grind or clench your teeth? Yes No

Do you brush/floss daily? Yes No

Do you see a hygienist regularly? Yes No

How would you rate your smile on a scale of 1 to 10? (10 being perfect) _____

If you are currently experiencing pain, or have a dental concern, please answer the following questions:

Where abouts in your mouth? _____

If you have pain, is it constant or intermittent? _____

If intermittent, is it made worse
by any of the following (please circle) Hot Cold Sweet Chewing

Are you taking pain medication Yes No

Do you have any of the following: (please tick)

Swelling	<input type="checkbox"/>	Issues with a bridge	<input type="checkbox"/>
Loose tooth	<input type="checkbox"/>	Lost Crown	<input type="checkbox"/>
Lost filling	<input type="checkbox"/>	Broken denture	<input type="checkbox"/>
Broken Tooth	<input type="checkbox"/>		<input type="checkbox"/>

How long has this been bothering you? _____

I understand that if I fail to give 48 hours' notice to cancel my appointment, that a fee may be charged. I agree to be responsible for payment of all services rendered on my behalf, and on the behalf of my dependents understand that this payment is due at the time of service unless other arrangements have been made.

Preferred me method of payment: EFTPOS Payment Plan Cash Medicare (Child Dental Benefit Scheme) DVA

Patient/responsible partys Name : _____ Date : _____

Parent/responsible partys signature : _____

Relationship to patient: _____