Please read and answer all that apply.

We value your privacy, all details will be kept strictly confidential.

**PERSONAL DETAILS**

Please Circle Title: Master Mr Miss Ms Mrs Dr (Other………………)

First Name:………………………………………………………… Surname:………………………………………………….

Preferred Name:……………………………………………….. Date of Birth: …………………………………………..

Address:…………………………………………………………………………………………………………………………………..

…………………………………………………………………………………………... Post Code:………………………

Mobile Phone:……………………………………………. Home Phone:…………………………………………………..

Occupation: …………………………………………… Work Phone (Emergencies only)……………………………….

Email: …………………………………………………………………………………………………………………………

Emergency Contact Name: ……………………………………………………………

Contact No: ……………………………………………… Relationship to you: ……………………………………………...

Do you have any private health insurance? YES / NO (If yes, please specify below)

Health fund name:………………………………………… Member number: (Eg, 01)…………

**DENTAL DETAILS**

When was your last dental examination? ……………………………………………………………………………………………

What is the primary reason for your visit today? …………………………………………………………………………

Are you currently experiencing pain or have a dental problem? YES / NO

(Please list) …………………………………………………………………………………………………………….

Have you ever been diagnosed or treated for Gum Disease? YES / NO

Are you a nervous, anxious or ever had a bad experience at a dental visit? YES / NO

(Please list) …………………………………………………………………………………………………………….

Are you happy with the appearance of your teeth and smile? YES / NO

(If no, please explain) ……………………………………………………………………………………………………………..

**MEDICAL DETAILS**

Do you have, or have you had the following: (please tick all that apply and specify below)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Heart Disease |  | High blood pressure |  | Hepatitis A, B or C |  |
| Blood disease |  | Low Blood pressure |  | Liver disease |  |
| Valve Disorder |  | Cardiac Pacemaker |  | Contact with HIV?AIDS |  |
| Heart Murmur |  | Tuberculosis |  | Nervous condition |  |
| Bronchitis |  | Stroke |  | Creutzfeldt-Jakob Disease |  |
| Diabetes Type 1, 2 or 3 |  | Asthma |  | Emphysema or other lung disease |  |
| Steroid Therapy |  | Rheumatic fever |  | Stomach or digestive condition |  |
| Kidney Disease |  | Thyroid disease |  | Prosthetic E.g. Shunt |  |
| Epilepsy |  | Cancer |  | Radiation or Chemotherapy |  |
| Excessive Bleeding |  | Anaemia |  | Leukaemia |  |

Name of your GP: ……………………………………………………. Phone No: ……………………………………….

Are you being treated by a doctor at present? YES / NO

Name of your Medical Doctor: ………………………………… Phone No: ……………………………………….

Do you take any prescribed drugs, tablets, medicines or creams? YES / NO

Please Specify: …………………………………………………………………………………………………………………………………………………………….. ……………………………………………………………………………………………………………………...................……………………………………….......

Have you had any allergic reactions to any treatments, medications or substances? YES / NO

Please Specify: ……...……………………………………………………………………………………………..........................................................

Have you been a patient in hospital in the last 5 years? YES / NO Please Specify: ……………………………………………………….

Do you smoke? YES / NO / EX-SMOKER

Ladies, are you pregnant? If so, how many weeks? ...............................

**Would you like to discuss or find out more information about any of the following:** (Please circle)

Replacement of missing teeth Cosmetic appearance Removal of wisdom teeth

Teeth whitening Bad breath Bleeding gums Tooth grinding / Clenching

Replacement of silver (mercury) fillings Dentures Implants

**How did you hear about us?** ………………………………………………………………………………………..

**CONSENT**

• I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable and I will assume responsibility for the fees associated with those procedures.

• I understand diagnostic tools such as x-rays, photographs and study models may be required prior to the commencement of certain dental procedures.

• I am aware that full payment is required on the day of treatment.

• I acknowledge that the information given on this form is true and accurate to the best of my knowledge. It is my responsibility to inform the dentist of any changes in my medical status.

• I consent to health professionals who have treated me exchanging information about me as required via phone, mail or email to assist in providing oral health care to me.

Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_