It is our pleasure to welcome you to our practice.
We are dedicated to providing you with the highest standard of professional care.

Personal Information

Title: Mr. / Mrs. / Ms. / Miss / Mast / Prof. / Dr. / Other ___________

First name: _________________ Surname: __________________ Preferred Name: ________________________

Date of birth: __________________ Occupation: ____

Ph: ___________________ Work: _________________ Mobile: _______________________________________

Email: ________________________________@____

Address: ____

____Post Code: _____________________________

Preferred contact method: ☐SMS ☐Phone ☐Email ☐Letter

Dental History

When was your last Dental Visit? ____

Previous dental X-rays were taken: ☐ In the last 12 months ☐ Longer than 12 months ago

Have you had any problems with previous dental treatments? ☐Yes ☐No

If yes, what was your previous experience:

____

____

Preventative Care

Do you experience sensitivity with hot/cold? ☐Yes ☐No

Do your teeth ever hurt when biting hards? ☐Yes ☐No

Does flossing ever tear between your teeth? ☐Yes ☐No

Does food get caught between your teeth? ☐Yes ☐No

Do you grind your teeth? ☐Yes ☐No ☐Unsure

Do your gums ever bleed when brushing? ☐Yes ☐No

How did you find us (Please Complete)

❑ White Pages Online ❑ Yellow Pages Online ❑Internet – please specify _________

❑ GP referral ❑ Referral from an existing patient - who was the patient ___________________________

❑ External Signage ❑ Other (please specify) ____

Medical Questionnaire – Private and Confidential

Please answer the following or discuss with your dentist. All medical information is for your dentist's use only.

Past/Present Medical Conditions

Are you receiving any medical treatments at present? ☐No ☐Yes Details ________________________________

Do you suffer from any long term conditions or illnesses? ☐No ☐Yes Details ________________________________

Have you ever been hospitalized? ☐No ☐Yes Details ________________________________

Please indicate if you have EVER had any of the following:

Any heart complaint/treatment ☐
Rheumatic fever or heart valve surgery ☐
High or low blood pressure ☐
Blood disorder ☐
Anti-coagulant therapy ☐
Joint replacement therapy ☐
Osteoporosis or low bone density ☐
Epilepsy ☐
Diabetes ☐
HIV ☐

Do you Smoke?
☐No ☐Yes How often: ______________

Tuberculosis ☐
Nervous system disorder ☐
Gastric ulcer ☐
Asthma/Bronchitis/Lung condition ☐
Radiation therapy/Chemotherapy ☐
Thyroid disease ☐
Hepatitis/Jaundice or Liver disease ☐
Treatment for any form of cancer ☐
Transplanted organ or bone marrow
Women only: Are you pregnant? ☐
Due Date: ______________________
Other: ______________________

Current Medications (prescription, herbal, over the counter pharmacy):
____

____

Allergies: ☐Nil known ☐ Yes

Details:____

Privacy, Billing and Consent

In accordance with the Privacy Act (2001) all information collected in this practice is treated as 'sensitive information'. To protect your privacy, this practice operates in accordance with the act.
We use the information you provide to manage your health care. You can assist in maintaining the accuracy of your information by advising the practice of changes of address, phone numbers etc.

Consent for treatment:
I hereby authorize the dentists or designated team to take x0rays, study models, photographs and other diagnostic aids deemed appropriated by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anaesthetics, sedatives and other medication as necessary. I understand that using anaesthetic agents pose certain risks. I understand I may request additional information regarding these risks and any possible complications.
I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time if service unless other arrangements have been made.

I understand this data may be reviewed by team members of the dental practice for the benefit of my dental health.

I, ____, understand and consent to the above statements.

Signature: __________________________________ Date: __________________

Relationship to patient (if patient is under 18) ________________________________