

In order to provide you with dental treatment, we require information about your health status, and your personal contact details. This information is only used in conjunction with providing you with dental care. The information is stored in accordance with the relevant government legislation.

PERSONAL INFO

Mr / Mrs / Miss / Ms / Miss / Mstr / Dr / Prof / other

Surname:..... First Name:..... Middle Name:.....

Date of Birth:..... Languages spoken (other than English)

Address:.....Pcode.....

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

Email:.....

Emergency contact person Phone

WORK / SCHOOL

Occupation:.....

Company Name:..... Work Phone number

for school age kids School name Grade

HEALTH FUND

Extra's cover? YES / NO Name of fund Single / Couple / Family

Membership numberDate of last dental visit:.....

REFERRAL

How did you hear about us?

If a friend recommended you to us, their name

MEDICAL HISTORY

Your medical history will be reviewed routinely in accordance with the Dental Practice Board of Victoria Guidelines. Do you have a **history** (at any time) of the following? Circle all applicable.

- | | | |
|--------------------|---------------------------|------------------------------|
| RHEUMATIC FEVER | DIABETES | HIGH OR LOW BLOOD PRESSURE |
| EXCESSIVE BLEEDING | ARTIFICIAL HIP/KNEE/ANKLE | PACE MAKER |
| EPILEPSY | PENICILLIN ALLERGY | OTHER HEART RELATED AILMENTS |
| OSTEOPOROSIS | BONE PROBLEMS | THYROID PROBLEMS |
| STROKE | TUBERCULOSIS | ASTHMA |
| KIDNEY ISSUES | HEPATITIS /LIVER DISEASES | HIV/AIDS RELATED CONDITION |

SEE NEXT PAGE

Have you **ever** suffered a serious illness? Please give details and approx dates (or at least the year)

Any Allergies?..... Adverse reactions to Anesthetics?

Are you presently receiving medical attention?

Details:.....

Name and phone of your GP:.....

Are you currently taking any medicines or tablets? Or in the last 12 months?

Details:.....

Are you currently, or have you recently, undertaken any psychiatric treatment? YES / NO

Do you smoke? YES / NO How many per day Drink Alcohol? YES / NO

For women, are you pregnant? YES / NO Due date:.....

LIFESTYLE (*optional questions*)

Do you snore? YES / NO Do you wake with sore jaws or pain in neck/shoulders? YES / NO

Do you suffer from Tinitis (ringing in the ears)? YES / NO Does your jaw click or crack? YES / NO

How many times a day do you brush your teeth?

What type of toothbrush do you use ? MANUAL / ELECTRIC which brand?

What type / brand of tooth paste do you use ?

Do you floss? YES / NO If yes, how often?

Are you happy with your smile?

Have you ever considered undertaking teeth whitening?

Are you concerned about how your teeth will function in later life?.....

Do you have sensitivity to cold or hot on a regular basis?

If there was one thing you could change about the dentist, what would it be

DECLARATION

It is important that the information given above are true and correct as it may affect the dental treatment options given to me.

I understand payment is required at the time of treatment by cash, Eftpos, major credit cards.

Client's signature:..... Date:.....

Dentist signature:..... Date:.....Initials