all about teeth
keeping your smile for life

HEALTH HISTORY

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other: Date of Birth : _____ /_____ /_____

First Name: _____ Surname: _____

Address: Street: _____ Suburb: _____

State: _____ Postal Code: _____

Home No: _____ Work No: _____ Mobile: _____

Email Address: _____

Preferred Contact: Email [ ] SMS Mobile [ ] Call Mobile [ ] Call Work [ ] Call Home [ ]

Who can we thank for your referral: Name: _____

Yellow Pages: Online [ ] Phonebook [ ] Google [ ] Television [ ] Radio [ ] Other: _____

Private Health Cover (if applicable): _____

Occupation: _____

Primary Dental concern: _____

Are you pregnant? _____

Do you require antibiotic cover prior to dental treatment? _____

Please tick yes or no to the following questions:

Y	N		Y	N	
☐	☐	Heart Problems	☐	☐	Have you been diagnosed with HIV / Aids
☐	☐	High blood pressure	☐	☐	Blood Disorders
☐	☐	Low blood pressure	☐	☐	Diabetes
☐	☐	Artificial Joints	☐	☐	Hepatitis A B C DE
☐	☐	Rheumatic Fever	☐	☐	Liver Problems
☐	☐	Osteoporosis or Bone Treatment	☐	☐	Kidney Problems
☐	☐	Radiation Treatment	☐	☐	Tumor History
☐	☐	Excessive Bleeding	☐	☐	Epilepsy
☐	☐	Asthma			
☐	☐	Allergies (Please list): _____			

If you have ticked yes to any of the above please specify:

Please list any Drugs or Medications (Including natural things) you are currently taking:

Have you had a look at the information on our website? ☐ Yes / No ☐

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Have you had or do you suffer from any of the following?

Y	N	
☐	☐	Do you wear a dental night guard or a dental splint?
☐	☐	Have you ever had periodontal (gum) treatments?
☐	☐	Do you smoke?
☐	☐	Do you think you have occasional bad breath?
☐	☐	Do your gums ever bleed when you brush or floss
☐	☐	Does floss ever tear between your teeth?
☐	☐	Do you snore?

How often do you brush your teeth?

☐ occasionally ☐ once a day ☐ twice a day ☐ more than twice a day

How often do you floss?

☐ never ☐ 1 - 3 times a week ☐ 4 -5 times a week ☐ every day or more

The name of your physician: _____

Medical centre of your physician: _____

How long since your last dental appointment? _____

How often do you have dental examinations? _____

Previous dental x-rays were taken:

☐ Less than one year ☐ Longer than one year

Consent for Treatment

1. I herby authorise the dentist or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.

2. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.

4. 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 of service unless other arrangements have been made.

[ ] We do occasionally send out newsletters, usually with things we hope are relevant. Please tick wish to opt out.

Patient's Signature: _____ Date: _____

Name of Parent or Guardian if applicable: _____

Parent / Guardian Signature: _____ Relationship to patient: _____

We expect and appreciate payment at time of service.
We accept all major credit cards, (visa, mastercard) personal cheque, eftpos and cash.
We require a minimum of 48hrs notice to change appointments otherwise a cancellation fee may apply.