



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: \_\_\_\_\_

Who can we thank for your referral: \_\_\_\_\_

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

Heart Problems

High blood pressure

Low blood pressure

Artificial Joints

Rheumatic Fever

Circulatory Problems

Radiation Treatment

Excessive Bleeding

Excessive Bruising

Ulcers (stomach)

Sinus Trouble

Asthma

Y N

Allergies to Anaesthetic s

Allergies to Penicillin or Medications

Allergies to Latex

Have you been diagnosed with HIV / Aids

Anaemia

Blood Disorders

Diabetes

Hepatitis A B C D E

Liver Problems

Kidney Problems

Tumor History

Epilepsy

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

\_\_\_\_\_

Please list any Drugs or Medications you are currently taking: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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

- | Y                        | N                        |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wear a dental night guard or a dental splint? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had periodontal (gum) treatment?       |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you think you have occasional bad breath?         |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your gums ever bleed when you brush or floss      |
| <input type="checkbox"/> | <input type="checkbox"/> | Does floss ever tear between your teeth?             |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you snore?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there anything else you would like us to know?    |

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 hereby 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.

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Parent or Guardian if applicable: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**SEND**

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.

