



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

First Name: _____ **Surname:** _____

Address: Street: _____

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 Anaesthetics
- 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 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 24hrs notice to change appointments otherwise a cancellation fee may apply.

