



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	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Rheumatic fever or heart valve surgery	<input type="checkbox"/>	Nervous system disorder	<input type="checkbox"/>
High or low blood pressure	<input type="checkbox"/>	Gastric ulcer	<input type="checkbox"/>
Blood disorder	<input type="checkbox"/>	Asthma/Bronchitis/Lung condition	<input type="checkbox"/>
Anti-coagulant therapy	<input type="checkbox"/>	Radiation therapy/Chemotherapy	<input type="checkbox"/>
Joint replacement therapy	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>
Osteoporosis or low bone density	<input type="checkbox"/>	Hepatitis/Jaundice or Liver disease	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Treatment for any form of cancer	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Transplanted organ or bone marrow	<input type="checkbox"/>
HIV	<input type="checkbox"/>	Women only: Are you pregnant?	<input type="checkbox"/>
		Due Date: _____	
		Other: _____	

Do you Smoke?

No Yes How often: _____

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 x-rays, 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 of 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) _____