

Name:

Address:

Date of Birth:

Phone:

Home:

Work:

Mobile:

E-mail:

Best way to contact (please circle) Home / Work / Mobile

Person responsible for fees, if not self:

(NB: Fees are payable at each visit – if this presents a problem, please let us know).

Occupation: Dental Insurance company

Medical History

Name of your General Practitioner:..... Phone:.....

Purpose of visit today:.....

Have you had any of the following?

Heart problems/murmur	<input type="checkbox"/> Yes	Allergies to anaesthetics	<input type="checkbox"/> Yes
Blood pressure	<input type="checkbox"/> Yes	Allergies to penicillin	<input type="checkbox"/> Yes
Artificial joints	<input type="checkbox"/> Yes	Allergies to medications	<input type="checkbox"/> Yes
Rheumatic fever	<input type="checkbox"/> Yes	Allergies to latex	<input type="checkbox"/> Yes
Circulatory problems	<input type="checkbox"/> Yes	Anemia or other blood disorders	<input type="checkbox"/> Yes
Radiation treatment	<input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> Yes
Excessive bleeding	<input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> Yes
Excessive brushing	<input type="checkbox"/> Yes	Hepatitis A B C D E	<input type="checkbox"/> Yes
Ulcers (stomache)	<input type="checkbox"/> Yes	Epilepsy	<input type="checkbox"/> Yes
Sinus trouble	<input type="checkbox"/> Yes	Liver or kidney problems	<input type="checkbox"/> Yes
Tumor history	<input type="checkbox"/> Yes		

Are you currently taking any prescribed medication? Yes

If yes, please specify:

(e.g. hormone replacement therapy, high blood pressure, corticosteroids)

Have you been hospitalised recently? Yes

If yes, please specify:

Ladies: Are you pregnant? Yes What is the due date?.....

Does food get jammed between your teeth?	<input type="radio"/> Yes	Do you bite your lips or cheek often?	<input type="radio"/> Yes
Does your jaw click or hurt?	<input type="radio"/> Yes	Do you smoke?	<input type="radio"/> Yes
Do you feel you grind your teeth?	<input type="radio"/> Yes	Do you think you have occasional bad breath?	<input type="radio"/> Yes
Have you ever had orthodontic treatment?	<input type="radio"/> Yes	Do you wear a night guard?	<input type="radio"/> Yes
Does floss ever tear between your teeth?	<input type="radio"/> Yes	Do you experience sensitivity with hot/cold?	<input type="radio"/> Yes
Have you ever had gum disease?	<input type="radio"/> Yes	Do your teeth ever hurt when you bite hard?	<input type="radio"/> Yes
Have you ever had your bite adjusted?	<input type="radio"/> Yes		
Do your gums ever bleed when you brush your teeth?	<input type="radio"/> Yes		
Do you suffer from headaches or neck aches?	<input type="radio"/> Yes		
If so, how frequently?			
Weekly <input type="radio"/> Twice a month <input type="radio"/> Monthly <input type="radio"/> Less than monthly <input type="radio"/>			

Does having dental treatment worry you? Yes

If yes, how can we make your visit more comfortable?

.....

Are you taking any alternative medicines? Yes No

If yes, please specify:

(e.g. vitamin supplements, herbal medicine, homeopathic remedies)

Have you been advised to have antibiotic cover prior to dental treatment? Yes No

Is there anything else you would like us to know?

Is there anything you would like to discuss in private with your dentist? Yes No

Consent for treatment

I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. 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. 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. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand that payment is due at the time of service unless other arrangements have been made.

I authorise that this data may be reviewed by team members of the dental practice.

Signature:

Date:

Parent/responsible party's signature:.....

Relationship to patient:.....