



Please note that all information on this medical/dental form will remain strictly confidential. Please complete in CAPITAL LETTERS.

Surname		Given Names	
Date of Birth		Occupation	
Phone (H)	<input type="checkbox"/>	Home Address	
Phone (W)	<input type="checkbox"/>		
Phone (Mobile)	<input type="checkbox"/>		
(Please tick the box that you prefer we contact you on)			
Email address			
Health Fund		Member Number:	
Emergency contact (please provide name and phone number):			

To complete only if the patient is under 18 years old

Guardian Name & Contact Address/Phone Details	
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Referral Information

<input type="checkbox"/> Internet/Website <input type="checkbox"/> Walked past <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Village Voice <input type="checkbox"/> Patient (please provide name so that we can thank them) _____

MEDICAL HISTORY

Name of your GP:		Your Doctor's Phone No.	
Your Doctor's address:			

Have you ever had any of the following? Please tick those that apply:

<input type="checkbox"/> Anaemia	<input type="checkbox"/> Fainting	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Respiratory problems
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis A, B, C	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Stroke
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tumours
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/ AIDS	<input type="checkbox"/> Psychological Disorders
Are you pregnant? If yes, how many months?		

Have you had any serious illnesses in the last 2 years? If yes, please provide more information.	
Are you currently taking any medications or tablets regularly? If yes, please provide more information.	
Do you have any allergies to Penicillin or other drugs? If yes, please provide more information.	
Do you suffer from sleep apnoea?	
Is your blood pressure normal, high or low?	
Do you smoke? If so how many per day?	

DENTAL HISTORY

Are you concerned about or experiencing any of the following dental problems? (please tick as many as it applies)

- | | | |
|---|--|--|
| <input type="checkbox"/> sensitivity to hot or cold | <input type="checkbox"/> food trapping between your teeth | <input type="checkbox"/> clicking/pain in the jaw joints |
| <input type="checkbox"/> staining of your teeth | <input type="checkbox"/> discoloured fillings | <input type="checkbox"/> roughness of existing fillings |
| <input type="checkbox"/> bleeding gums | <input type="checkbox"/> bad breath | <input type="checkbox"/> sensitivity when eating |
| <input type="checkbox"/> head/neck ache | <input type="checkbox"/> grinding or clenching of your teeth | |

Are you concerned with: (please tick as many as it applies)

- | | | |
|--|---|---|
| <input type="checkbox"/> Existing crowns, bridges or dentures | <input type="checkbox"/> Ability to eat | <input type="checkbox"/> Gaps between your teeth |
| <input type="checkbox"/> Tooth clean techniques (e.g. Brushing / Flossing) | <input type="checkbox"/> Your smile | <input type="checkbox"/> Discolouration of your teeth |
| <input type="checkbox"/> Crooked teeth | <input type="checkbox"/> Missing teeth | <input type="checkbox"/> Previous dental treatment |
| <input type="checkbox"/> Silver fillings | | |

What is the main purpose of your visit today?

How long since your last dental visit? _____

Does dental treatment make you nervous? No Slightly Moderately Extremely

Have you ever had or require the following for dental treatment?

- | | | |
|---|---|--|
| <input type="checkbox"/> Gas (Nitrous oxide-laughing gas) | <input type="checkbox"/> Intravenous sedation | <input type="checkbox"/> General Anaesthesia |
|---|---|--|

I understand that payment is required on the day of treatment.

Signature: Date: Failure to give 24 hours notice for appointment changes incur a cancellation fee of \$50.00