ABOUT YOU

Mr/Mrs/Dr/Miss/Ms (please circle) Name: _____

I prefer to be called: _____

Birth date: _____ Age: _____

Home Address: _____

Contact number: _____

Email address: _____

How do you prefer to be contacted? ☐ Email ☐ Phone ☐ Text

Occupation: _____

Other family members seen by us: _____

How did you find out about us? ☐ Friend ☐ Google ☐ Instagram ☐ Other: _____
☐ Walking By ☐ Facebook ☐ Advertisement

Whom may we thank for referring you? _____

EMERGENCY CONTACT

In the event of an emergency, who would you like us to contact?

His / Her Name: _____

Relation: _____

Contact number: _____

DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Type of toothpaste? ☐ Regular ☐ Natural ☐ Whitening

Please turn over

MEDICAL HISTORY

Are you taking any prescription/over the counter medications or herbal supplements? ☐ Yes ☐ No

Please list: _____

Have you ever had any injections or taken any medications for bone-related diseases (eg. Prolia, Fosamax?) ☐ Yes ☐ No

Are you on any blood thinners? ☐ Yes ☐ No

Do you have any bleeding disorders or blood diseases? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

For women: Are you pregnant? ☐ Yes ☐ No Week number: _____

Do you have any of the following medical problems?

- ☐ Abnormal bleeding
- ☐ Alcohol/Drug Abuse
- ☐ Anaemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Bones/Joints/Valves
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Haemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hospitalised for any reason
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problem
- ☐ Raditation Treatment
- ☐ Rheumatic/Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease/Traits
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Please list any serious medical conditions that you have ever had:

_____

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Sulfur
- ☐ Erythromycin
- ☐ Sulphites
- ☐ Penicillin
- ☐ Metals
- ☐ Latex
- ☐ Tetracycline

Please list any of drugs/materials that you are allergic to: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Do you take any recreational drugs? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date

I understand that I am responsible for payment of any services rendered on the day, unless otherwise arranged. I am responsible for paying any gap fee that my health fund does not cover.

_____

Signature Date