WELCOME

Please take your time to answer these questions as completely as possible. It will assist us greatly in our effort to provide the best treatment for you.

All information will be treated with complete professional confidentiality.

Please print.

Title: _____ D.O.B: _____
Surname: _____
Given names: _____
Preferred name: _____
Address:_____
_____
City/Suburb: _____ Postcode: _____
Phone numbers: (H) _____
(W) _____ Extension number (if applicable) _____
Time to call: _____
(M) _____
Email address: _____
What method of contact do you prefer: _____
Occupation: _____
Hobbies: _____
Employer: _____
Emergency Contact & Phone Number: _____
Nearest relative's name (not at your address): _____
Address: _____
_____
City/Suburb: _____ Postcode: _____
Phone number: _____
Person responsible for fees: _____
What dental insurance, if any, do you have? _____
Please list any drugs, prescribed medication, over the counter / natural medicines or vitamins that you take regularly _____
_____
_____
_____
Have you had any bad reaction to any treatment or medication? Yes No
Have you had any serious health problems during the past year? Yes No
If you answered yes to either of the above two questions please provide details (eg. name/s of medications re. bad reactions or health problems): _____
_____
_____

Do you or have you suffered from in the past any of the following illnesses? Please indicate.

1. Heart murmur Yes No
2. Heat/vascular disorder Yes No
3. Blood disease/bleeder Yes No
4. High Blood pressure Yes No
5. Rheumatic fever/arthritis Yes No
6. Diabetes Yes No
7. Liver disease Yes No
8. Kidney disease Yes No
9. Asthma Yes No
10. Epilepsy Yes No
11. Allergies to Anaesthetics Yes No
12. Allergies to Penicillin Yes No
13. Allergies to Medications Yes No
14. Allergies to Latex Yes No
15. Artificial Joints Yes No
16. Circulatory Problems Yes No
17. Ulcers Yes No
18. Sinus Yes No

19. Other health problems Yes No
If yes to question 19, please list details - _____
_____
_____

Are you pregnant? Yes No
If yes, how many months? _____

Aids and Hepatitis are infectious and can be present in human body fluids.
This puts the dentist and staff who will be treating you in a vulnerable position when attending to patients who fall into a "risk" category.

Risk categories are:

- Carriers of Hepatitis
- Suspected or confirmed HIV Positive
- Homosexuals and Bisexuals
- Users of intravenous drugs of addiction
- Sexual partners of the above
-

Please tick the appropriate alternative:

I **could be** in a "risk" category ☐

I am **not** in a "risk" category ☐

I feel **unsure** how to answer ☐

What is the purpose of today's visit? _____
_____

For dental treatment, do you prefer injections? Yes No
Have you ever had any problems with dental injections? Yes No
If yes, please provide details of the problem? _____
_____

Have you ever had any of the following –

Does your jaw "click" or hurt?	Yes	No
Do you feel like you grind your teeth?	Yes	No
Do you wear a dental night guard?	Yes	No
Have you ever had orthodontic (braces) treatment?	Yes	No
Have you ever had periodontal (gum) treatment?	Yes	No
Have you ever had your bite adjusted?	Yes	No
Do you bite your lips or cheeks often?	Yes	No
Do you smoke?	Yes	No
Do you think you have occasional bad breath?	Yes	No
Do your gums ever bleed when you clean your teeth?	Yes	No
Do you experience sensitivity with hot/cold?	Yes	No
Do your teeth ever hurt when you bite hard?	Yes	No
Does floss ever tear between your teeth?	Yes	No
Does food ever get jammed between your teeth?	Yes	No
Is there anything else you would like us to know?	Yes	No

_____
_____
_____

Today's date: Signature:

_____ _____