Welcome to our practice. To help us ensure we are looking after your needs, please answer all questions as completely and accurately as possible on the following questionnaire:

SURNAME: _____ MR/MRS/MISS/MS/DR (Circle one)

FIRST NAME: _____ DATE OF BIRTH: ___/___/___

RESIDENTIAL ADDRESS: _____

P/CODE: _____

PRIVATE PHONE: _____ BUSINESS PHONE: _____

MOBILE: _____ E-MAIL: _____

OCCUPATION: _____

PERSON RESPONSIBLE FOR FEES (IF NOT SELF): _____

ADDRESS: _____

As we like to look after our patients for recommending us to new lovely clients, how did you find Our practice? _____

PURPOSE OF VISIT: _____

DENTAL INSURANCE COMPANY: _____

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR PRACTICE: _____

Have you had or are suffering from any of the following?

	Yes	No		Yes	No
Any heart problems	□	□	Allergies to Anaesthetics	□	□
Blood Pressure high/ low (circle)			Allergies to Penicillin	□	□
Artificial Joints	□	□	Allergies to Medications	□	□
Cardiac Pacemaker	□	□	_____		
Rheumatic Fever	□	□	Allergies to Latex	□	□
Circulatory Problems	□	□	Anaemia or other blood disorders	□	□
Radiation / Chemotherapy treatment	□	□	Diabetes, Type 1 OR Type II, (circle)		
Cancer History	□	□	Asthma	□	□
Excessive bruising	□	□	Hepatitis A B C D E	□	□
Excessive bleeding	□	□	Epilepsy	□	□
Ulcers (stomach)	□	□	Liver or Kidney problems	□	□
Sinus trouble	□	□	Osteoporosis	□	□
Sleep Apnoea	□	□			

Are you currently taking any Blood thinners medication? YES or NO. (circle)
Are you currently taking any drugs or medications?
If so please list: _____

Do you have any heart conditions?
If so please list: _____
_____

Please complete page two....

Are you pregnant? _____ Due Date: _____

Have you had any of the following?	Yes	No
Does your jaw "click" or hurt	□	□
Do you feel you grind your teeth?	□	□
Have you ever had orthodontic treatment?	□	□
Do you wear a dental night guard?	□	□
Have you ever had periodontal (gum) treatment?	□	□
Have you ever had your bite adjusted?	□	□
Do you bite your lips or cheeks often?	□	□
Do you smoke?	□	□
Do you think you have occasional bad breath?	□	□
Do your gums ever bleed when you clean your teeth?	□	□
Do you experience sensitivity with hot/cold?	□	□
Do your teeth ever hurt when you bite hard?	□	□
Does floss ever tear between your teeth?	□	□
Does food get jammed between your teeth?	□	□
Have you come into contact with HIV/AIDS?	□	□

Is there anything else you would like us to know? _____

_____

The name of your Medical Doctor _____

Address: _____

Postcode: _____ Phone Number: _____

How long since your last dental appointment? _____

How often do you have dental examinations? _____

Previous dental x-rays were taken: Less than 1 year □ More than 1 year □

Consent for tooth image use
We request the use of tooth images taken in the treatment room to be used for future patient education. All images will be used with strict confidentiality assured.
Please sign for agreement: Patient's signature: _____ Date: __ / __ / __

Consent for Services

- **As a condition of your treatment by this clinic we expect and appreciate payment at time of service, all emergency dental services included.**
- **Preferred payment (please circle): VISA, MASTERCARD, CHEQUE, EFTPOS AND CASH.**
- **Your appointment is reserved exclusively for you. Please allow 48 hours of prior notice if you wish to reschedule it. We do not accept cancellations by SMS.We reserve the right to charge a fee for lost appointment time.**

I have read the above conditions of treatment and agree to their content. To the best of my knowledge, all of my answers and information provided are true and correct. If I ever have any change in my health, I will inform the dentist at my next appointment.

Patient's signature: _____ Date:_____

Relationship to Patient (if applicable): _____

Signature of patient, parent or guardian