In the interest of your treatment, all questions must be answered to the best of your knowledge.
All information is kept strictly confidential.

Title	Mr, Mrs, Miss, Ms, Other……	Date of Birth	/ /
Surname		Given Name(s)	
Phone (H) Phone (W) Phone (mob)	□ □ □ Please tick preferred contact number	Address Suburb Post Code	
Email		Occupation	
Health Fund			

How did you hear about us?

1. Google search 2. Yellowpages online 3. Yellow pages book

4. Website 5. Advertisements 6. Billboard

7. Friends/family 8. TV 9. Other .....

If you were recommended by someone, who were they so that we may thank them?

……

It is important that you name the person who referred you as all of our patients receive rewards for their kind referrals!

MEDICAL HISTORY

Do you currently have, or have had any history of:

□ Heart Disease	□ Asthma	□ Epilepsy
□ Lung Disease	□ Blood Disease	□ Diabetes
□ Prosthetic Heart Valves	□ Heart Murmur	□ Hepatitis A, B, or C
□ Aids/HIV	□ Kidney Disease	□ Liver Disease
□ Pacemaker	□ Radiation Therapy	□ Rheumatic Fever
□ Bone Disease	□ Stroke	□ Tuberculosis
□ Excessive Bleeding	□ Cancer	□ Chemotherapy
□ Smoking	□ Artificial Joints	□ Sinus Problems

Would you like to take an holistic approach to your dental treatment? Yes/ No
(if you are unsure about the holistic approach to dentistry feel free to ask our staff)

Do you maintain a fluoride free lifestyle? Yes/ No

Any other illnesses? Yes/ No Please explain

……

Are you taking any medications? Yes/ No Please list

……

Are you taking any Vitamins or supplements right now? Yes/ No Please list

……

Are you currently, or have a history of taking Bisphosphonate containing medication? Yes/ No

Have you been in hospital recently? Yes/ No
Please explain…….

Are you allergic to penicillin? Yes/ No Any Other Allergies? ……

Are you pregnant? Yes/ No months?……

DENTAL HISTORY

Please describe what you would like to achieve from your visit today?

……

When was the last time you visited the dentist? Years …… Months……..

Are you concerned about or experiencing any of the following dental problems?

(tick as many as you think applies to you)

□ sensitivity to hot or cold
□ staining of your teeth
□ bleeding gums
□ head/neck ache
□ food trapping between teeth
□ discoloured fillings
□ bad breath
□ clicking or pain in jaw joints
□ pain when chewing/eating
□ chipped or rough fillings
□ grinding your teeth

Are you concerned with: (tick as many as you think applies to you)

□ existing crowns, bridges or dentures
□ missing teeth
□ previous dental treatment
□ ability to eat
□ crooked teeth
□ gaps between your teeth
□ silver fillings (amalgam)

Payment for services are required on the day of treatment, unless otherwise discussed with by the treating dentist. We have the **Hicaps** facility where we can claim for your benefits directly from your health fund. We also accept **Credit card** and **Cash.** We also offer **Interest Free** and **Payment Plans** from **Care Credit**, feel free to discuss this option with us. Unfortunately we do not accept personal cheques.

The practice requires at least 24 hours notice of any cancellations; failure to do so will incur a $50 cancellation fee.

We will endeavour to remind you the day before via sms of your appointment. However the responsibility is for you to remember your appointment details. Please discuss with us if you wish NOT to be reminded via sms.

Are you ok with x-rays or pictures taken of you or your teeth to be used for teaching or marketing purposes? Yes/No

Signature…… Date __ __/__ __/__ __ __ __

Do you have Facebook? Like us to receive a voucher towards your next treatment!

This form was printed on 100% recycled reflex paper.