So we can ensure we are looking after your needs, please review and complete the following questionnaire

Title: (Mr / Mrs / Miss / Ms / Dr) **First name:**	**Surname:**
Date of birth:	**Email:**
Residential Address:	**Postal Address:**
Home Phone: **Work Phone:**	**Mobile:**
Dental Insurance Company:	**Member No:** **Position on card (number next to name):**
Occupation:	**Name of person/company responsible for fees, if not self:**

How did you hear about us? Yellow Pages ☐ Internet ☐ Another patient ☐
(please give us their name so we can thank them) _____ Other _____

Is another member of your family a patient at our practice? No / Yes (name)_____

Are you pregnant or breastfeeding? N/A ☐ Yes ☐ If yes, when is the due date?_____

Purpose of visit: _____

Name of person to contact in case of emergency _____

Have you had any of the following? Please answer Y or N

Heart problems			Allergies to anaesthetic		
Blood pressure			Allergy to penicillin		
Artificial joints			Allergies to medication		
Rheumatic fever			Allergy to latex		
Circulatory problems			Anaemia / Blood disorders		
Radiation treatment			Diabetes		
Excessive bleeding			Asthma		
Excessive bruising			Hepatitis A B C D E		
Ulcers (stomach)			HIV		
Sinus trouble			Epilepsy		
Tumor history			Liver or kidney problems		

Any other medical conditions: _____

Are you currently taking any medications? Yes ☐ No ☐

If yes, please list: _____

_____

_____

Dental History (☑ if applicable)

Does your jaw click or hurt?	☐ **Yes**	**Do you smoke?**	☐ **Yes**
Do you feel you grind your teeth?	☐ **Yes**	**Do you think you have bad breath?**	☐ **Yes**
Have you ever had orthodontic treatment?	☐ **Yes**	**Do your gums bleed when you brush your teeth?**	☐ **Yes**
Do you wear a nightguard?	☐ **Yes**	**Do you experience sensitivity with hot/cold?**	☐ **Yes**
Have you ever had gum disease?	☐ **Yes**	**Do your teeth ever hurt when you bite hard?**	☐ **Yes**
Does floss ever tear between your teeth?	☐ **Yes**	**Does food get jammed between your teeth?**	☐ **Yes**

Other notes: _____

_____

Are you interested in teeth whitening? Yes ☐ No ☐

Name of your GP: _____

Clinic Details: _____

How long since your last dental appointment? _____

How often do you have dental examinations? _____

Previous dental x-rays were taken: Less than a year ago ☐ Longer than a year ☐

Consent for treatment

I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by my and to employ such assistance as required to provide proper care. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of services unless other arrangements have been made and accept responsibility for any debt collection fees. I authorise that this data may be reviewed by team members of the dental practice.

This is NOT a Government Health Clinic. We DO NOT Bulkbill

Patient signature: _____ **Date:** _____

Parent/responsible party's signature: _____

Relationship to patient: _____