Welcome to our Practice

Title:_____ Last Name: _____ First Name (s): _____

Home Address: _____ Post Code:_____

Preferred Mailing Address: _____Post Code: _____

Email Address: _____

Telephone: (Home) _____ (Work) _____ (Mobile) _____

Date of Birth: _____ Occupation: _____ Employer: _____

Next of Kin (Name and contact number) : _____

Do you have Dental Health Insurance? _____ Which Fund? _____

Who referred you to our Practice? (Please state) _____

The following questions are of a medical nature and will ensure that we are able to provide the very best possible care for you. Answers will be kept in strict confidence according to the Australian Dental Association Privacy Statement)

Who is your Doctor? _____ Telephone: _____

Are you under the care of a Doctor? If so, for what reason? _____

Are you taking any medications at present? If so, what is it? _____

Do you have any known allergies? (Eg. To medications, latex) _____

For females, are you pregnant? If so, how many months? _____

Are you a smoker? If so, how many per day? _____

Is there any reason for you to suspect that you are at risk of having HIV / AIDS or any other blood borne disease? _____

Do you normally require antibiotic cover before dental treatment? (Heart valve or joint prosthesis)
_____

Have you ever had an adverse reaction to any procedure performed by a dentist? _____

Have you ever had any bisphosphonates prescribed for osteoporosis or cancer? _____

Are you on blood thinning medication such as Warfarin , Aspirin? _____

Condition	Yes	No	Condition	Yes	No
High or Low Blood Pressure			Diabetes		
Heart Disorder or Heart Complaint of any Kind			Asthma, Bronchitis or other Lung Condition		
Chest Pain			Epilepsy		
Cardiac Pacemaker			Hepatitis or other Liver Condition		
Prosthetic Heart Valves or Joints			Kidney Disease		
Rheumatic Fever			Stomach or Digestive Condition		
Anaemia or Other Blood Condition			Organ or Marrow Transplant or Blood Transfusion		
Excessive or Prolonged Bleeding			Cancer or Tumour		

Do you have any other illness or disability? Please specify: _____

How long since your last dental appointment? : _____ How long since your last dental clean? _____

Risk factors affecting the oral environment are good predictions of future disease. Please help us manage your oral health by completing the following lifestyle analysis indicating the number of servings :

Daily sugar intake in between meals	
Daily intake acid drinks (soft / sports)	
Daily intake water	
Daily intake caffeine	
Daily intake alcohol	

Please indicate if you feel you have the following :

Dry mouth (day / night)	
Lifestyle stress	
Tooth ache	
Sensitive teeth (hot / cold)	
Bleeding gums	
Loosening teeth	
Missing teeth	
Unsatisfactory denture	
Rapidly decaying teeth	
Lost filling – cavity	
Grinding / clenching of teeth	
Worn / broken teeth – sharp points	
Pain in face or jaw joints	
Sounds (clicking) from jaw	
Difficulty / discomfort when chewing	
Heavy snoring / sleep apnea	
Discoloured teeth (restorations)	

Is there any problem in particular that concerns you? _____

How do you rate the appearance of your smile (1....10) _____

In a perfect world how would you want your smile to rate (1.....10) _____

Please remember what you did yesterday to clean your teeth

	Not at all	Once	Twice	More than twice
Yesterday I brushed my teeth				
Yesterday I flossed my teeth				
Yesterday I used another cleaning aid				

What other aid did you use? _____

Please help us to understand how you feel about dental treatment :

Calm / relaxed		Slightly anxious		Extremely tense	

I hereby state that I have understood and answered the questions to the best of my knowledge

Patient's Signature : _____ **Date :** _____