

**PATIENT REGISTRATION**

**123 DENTAL**

**123 Cambridge Street, West Leederville 6007**

**Ph: 9381 3806 Fax: (08) 9381 3808**

**Welcome to West Leederville Family Dental! So that we may provide you with the best possible dental care please complete BOTH sides of this Medical and Dental History Form. All information is completely confidential.**

Surname \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work Phone \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Email Address \_\_\_\_\_

Do you have private health cover? Yes No Fund and number \_\_\_\_\_

Which method of payment would you prefer? Cash Cheque Eftpos Credit Card Interest-free GE finance

Who can we thank for referring you to us? \_\_\_\_\_

**Medical History**

Have you been under medical treatment during the past two years? Yes / No If so for what? \_\_\_\_\_

Are you taking any medication? Yes / No Please List \_\_\_\_\_

Are you aware of any allergic or adverse reactions to any medication or substance? \_\_\_\_\_

**Indicate by circling yes or no, which of the following you have had or have at present.**

Heart problems	Yes	No	which?	Surgery, Pacemaker, High BP, Murmur, Congenital				
other	_____							
Chest Problems	Yes	No	what type?	Tuberculosis, Chronic Cough, Asthma, Emphysema				
other	_____							
Rheumatic Fever	Yes	No	Arthritis	Yes	No	Cortisone Medicine	Yes	No
Stroke	Yes	No	Ulcers	Yes	No	Thyroid Problems	Yes	No
Hay fever	Yes	No	Latex sensitivity	Yes	No	Sinus Problems	Yes	No
Radiation/chemotherapy	Yes	No	Hepatitis	Yes	No	AIDS/ HIV	Yes	No
Cold sores	Yes	No	Haemophilia	Yes	No	Epilepsy	Yes	No
Fainting/dizzy spells	Yes	No	Allergies	Yes	No	type	_____	
Psychiatric/psychological care	Yes	No						

Have you had any problem, disease or condition not listed above? \_\_\_\_\_

**Women** Are you: **Pregnant** Yes \_\_\_\_\_mths No **Nursing?** Yes No **Taking birth control Pills?** Yes No

**PLEASE TURN OVER**

**DENTAL HISTORY**

Reason for today's visit?     Check up     Toothache     Lost filling/cavity     Bleeding gums  
 Unhappy with appearance of teeth     Missing / worn / loose teeth     Poor dentures     Jaw soreness  
 Other (give details) \_\_\_\_\_

Date of last dental Visit \_\_\_\_\_ Last Cleaning \_\_\_\_\_ Last X-rays \_\_\_\_\_  
Previous Dentists Name \_\_\_\_\_  
Phone \_\_\_\_\_ How often do you have dental examinations? \_\_\_\_\_  
How often do you brush your teeth? Never / Once / Twice / Three times a day  
How often do you floss? \_\_\_\_\_ Do you use other aids? (mouthwash, toothpick, etc) \_\_\_\_\_

**Are any of your teeth sensitive to:**  
Hot or cold                      Yes    No  
Sweets                              Yes    No  
Biting or chewing              Yes    No

**Do your gums bleed or hurt?**  
Have your parents experienced gum disease or tooth loss? Yes    No  
Does foods tend to get trapped between your teeth?              Yes    No  
Have you noticed any loose teeth or change in your bite? Yes    No  
Have you noticed any mouth odours or bad tastes?              Yes    No  
Do you get sores, blisters or any other oral lesions?              Yes    No

**Have you ever had:**  
Orthodontic treatment              Yes    No  
Oral Surgery                              Yes    No  
Periodontal treatment              Yes    No  
Bite Plate Or Mouth Guard        Yes    No  
Serious injury to mouth or head    Yes    No

**Have you experienced:**  
Clicking, popping or sore Jaw    Yes    No  
Pain (joint, ear, side of face, sinus)                                      Yes    No  
Difficulty opening or closing mouth                                      Yes    No  
Difficulty chewing    Yes    No  
Clenching and or grinding    Yes    No

**Are you satisfied with your teeth's appearance?**                      Yes    No  
Would you like to keep your teeth for the rest of your life              Yes    No  
How do you feel about having dental treatment?    **CALM**    **APPREHENSIVE**    **NERVOUS**    **EXTREMELY NERVOUS**  
What is your biggest concern \_\_\_\_\_  
Have you ever had an upsetting dental experience                      Yes    No    If yes please describe \_\_\_\_\_

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the dentist of any change in my health or medication.

**Please be aware that we require full payment on the day. For larger accounts we offer Interest-Free Finance with GE. If accounts exceed our terms and conditions it will be sent to a collection agency and you will be responsible for all fees and charges incurred.**

**Please feel free to discuss any aspect of your treatment with the dentist or the receptionists.**

Signature \_\_\_\_\_ Date \_\_\_\_\_