PATIENT REGISTRATION

123 DENTAL
123 Cambridge Street, West Leederville 6007
Ph: 9381 3806 Fax: (08) 9381 3808

Welcome to 123 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.

Mr/Mrs/Ms/Miss/Dr/Other Surname _____ First Name: _____

Date of Birth _____ Occupation: _____

Home Address:_____ Postcode: _____

Home phone: _____ Work Phone: _____

Mobile Phone: _____ Email Address: _____

Next of Kin: _____ Relationship: _____

Contact Address: _____ Contact Phone: _____

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? _____

Reason for today's visit? __ Check up __ Toothache __ Lost filling/cavity __ Bleeding gums

__ Missing / worn / loose teeth __Poor dentures __ Jaw soreness __ Other (give details) _____

Are you satisfied with your teeth's appearance? Yes / No
Want whiter teeth? Yes / No
Would you like to discuss a smile make over with your dentist? Yes / No

Dental History

Date of last dental Visit _____ Last Cleaning _____ Last X-rays_____
Previous Dentists Name _____ Address_____
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

PLEASE TURN OVER

How do you feel about having dental treatment? **CALM** **APPREHENSIVE** **NERVOUS** **EXTREMELY NERVOUS**

Have you ever had an upsetting dental experience Yes No If yes please describe _____

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 If yes, please list _____

Please describe your medical condition for which you are taking the medication? _____

Are you aware of any allergic or adverse reactions to any medication or substance? ___Yes / No If yes, please describe _____

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

Heart problems Yes No please describe, eg (Surgery, Pacemaker, Murmur, Congenital)
other, please describe _____

Chest Problems Yes No please describe, eg (Tuberculosis, Chronic Cough, Asthma, Emphysema)
other, please describe_____

Orthopaedic Surgery Yes No please describe, eg (knee or hip replacement)

High Blood Pressure	Yes	No	Diabetes	Yes	No	Type I or Type II		
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? _____
Do you smoke? Yes / No

Female Patients Only:

Are you: **Pregnant?** Yes _____ mths No **Nursing?** Yes No **Taking birth control Pills?** Yes No

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_____

Missed appointments or same day cancellations will incur a fee!!