

**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) \_\_\_\_\_

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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

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!!**