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Please note that all information on this medical/dental form will remain strictly confidential.

Surname _____ Title _____
 Given Names _____ Date of Birth _____
 Home number _____ Work Number _____
 Mobile number _____
 Email _____ Fax _____
 Home address _____
 Preferred method of contact Phone Email SMS
 Occupation _____
 If the patient is a minor please note below the name of the parent or guardian completing this form
 Surname _____ Title _____
 Given Names _____

Name of your Doctor: _____ Phone number: _____
 Female patients: Are you pregnant? _____ How many Months? _____
 Have you had any serious illnesses? _____
 If yes please indicate: _____
 Are you currently taking any medications or tablets regularly? Eg. Aspirin, Bisphosphonate
 If yes please indicate: _____
 Do you have any allergies to Penicillin or other drugs? _____
 Is your blood pressure normal, high or low? _____
 Do you smoke? _____ How many per day? _____
 In case of an emergency please contact:
 Name: _____ Phone number: _____

Have you ever had any of the following? Please tick those that apply to you:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tumours or cancers	<input type="checkbox"/> Stroke
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Blood disease
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Anaemia
<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> Excessive bleeding
<input type="checkbox"/> High/Low BP	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Endocarditis	<input type="checkbox"/> Respiratory problems	<input type="checkbox"/> Fainting / Dizziness
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Hepatitis: Type _____	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other - specify _____
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Psychological problems	

Referral Information

Whom may we thank for referring you to our practice? _____

If not a direct referral please circle: Other - please indicate _____

Internet Website Yellow pages Phone book Newspaper Walked past

Are you concerned about any of the following dental problems?

- | | |
|--|---|
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Discoloured fillings |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Roughness of any existing fillings |
| <input type="checkbox"/> Bad taste | <input type="checkbox"/> Staining of your teeth |
| <input type="checkbox"/> Sensitivity when eating or hot/cold | <input type="checkbox"/> Head/neck ache |
| <input type="checkbox"/> Food trapping between your teeth | <input type="checkbox"/> Grinding or clenching your teeth |
| <input type="checkbox"/> Tooth sore or loose | <input type="checkbox"/> Clicking or pain in the jaw joints |
| <input type="checkbox"/> Tooth missing or has moved | |

Are you concerned with: -

- The appearance of your teeth
- Existing crowns, bridges or dentures
- Ability to eat
- Cleaning techniques e.g. brushing & flossing
- Your smile
- Snoring

What is the main purpose of your visit? _____

How long since your last dental visit? _____

Does dental treatment make you nervous? No Moderately Slightly Extremely

Do you also feel you require:

- Gas (Nitrous oxide-laughing gas) Intravenous sedation General Anaesthesia

Consent for services

- This is to certify that I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated and I will assume responsibility for the fees associated with those procedures.
- I understand that the practice requires at least 48 hours notice if I need to cancel my scheduled appointment and that a fee of \$200 will incur if I fail to do so.
- I hereby consent to the use of any study models, x-rays, computer images and photographs* at various dental seminars, lectures, and publications that the dentists may author.
- I am aware that payment is required on the day of treatment.

Signature of patient (parent or Guardian): _____ Date: _____

* Identity will not be revealed