Glenferrie Dental

This form will help us provide you with dental care of the highest standard.

All information will remain strictly confidential and is protected by Federal Privacy Legislation.

Title ______________________

Family Name ______________________

First Name ______________________

Preferred name ______________________

Date of Birth ______________________

Home Address

____

____

____

Postal Address (if different to above)

____

____

____

Business Address

____

____

____

Phone No. Home ______________________

Work ______________________

Mobile ______________________

Email ______________________

Occupation ______________________

Dental Insurance: ☐YES ☐ NO

Which fund? ______________________

Emergency Contact

Name ______________________

Phone No. ______________________

How did you hear about us? ______________________

MEDICAL HISTORY

Please tick ONLY those that apply to you:

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hospitalised in last 2 years
- ☐ HIV / AIDS
- ☐ Heart disease / trouble
- ☐ Hepatitis A, B or C
- ☐ Smoker
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Kidney or Liver disease
- ☐ Excessive bleeding
- ☐ Pacemaker
- ☐ Thyroid problems
- ☐ Blood disorder
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Cancer / Radiotherapy

Do you have any allergies? ☐YES ☐ NO

Please specify ______________________

List all tablets / medicines etc. you currently take

____

____

Do you have a heart murmur, pacemaker, artificial heart valves or artificial joints? ☐YES ☐ NO

Do you require antibiotics before dental treatment, now, or in the past? ☐YES ☐ NO

Are you taking Fosamax (or any other medication) to combat osteoporosis? ☐YES ☐ NO

Ladies, could you be pregnant? ☐YES ☐ NO

Would you like to discuss these questions in private with the dentist? ☐YES ☐ NO

Your Medical Doctor (Clinic)'s Name

____

Phone No. ______________________

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DENTAL HISTORY

Is there anything in particular you wish to discuss with us today? Please briefly describe.

____

____

Do you have any concerns about previous dental treatment you would like to discuss? ☐YES ☐ NO

Please tick ONLY those that apply to you:

☐ In the last month have you had any pain in your mouth?

☐ Do your gums bleed when you brush or floss?

☐ Does floss catch or shred in some places?

☐ Does food regularly lodge between particular teeth?

☐ Are your teeth sensitive to temperature or brushing?

☐ Do you have a tooth / teeth which looks darker than the others?

☐ Are you concerned about your breath?

☐ Does a gap or missing teeth force you to chew mostly on only one side?

☐ …or make it harder to chew some foods?

☐ Do you have a denture you wish you didn't have to wear?

☐ Do you suffer recurrent headaches? Many headaches can be relieved by relatively simple dental devices.

☐ Does your jaw click?

☐ Do you wake with a sore or 'tired' jaw?

☐ Do you have worn, chipped or uneven tooth edges that bother you?

☐ Are you a snorer or mouth breather?

☐ Do you play contact sport?

☐ Do you wish your teeth were whiter?

☐ Do you wish your teeth were straighter?

☐ Do you have spaces or 'gaps' but wish you didn't?

☐ Do you have old fillings or other dental work that cause you discomfort or you dislike?

How would you rate your smile on a scale of 1–10?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How would you improve your smile? (please tick)

☐ Improve colour

☐ Improve tooth shape

☐ Change old, discoloured fillings

☐ I understand I am personally responsible for all dental services rendered.

☐ I acknowledge that payment is appreciated and expected on the day of treatment.

☐ In the event of non-payment you agree to us sending your details to a 3rd party.

Signed ______________________________

Date ______________________________

NB: For under 18s, this form must be signed by a Parent / Guardian.

Thank you
Glenferrie Dental

www.glenferriedental.com.au

EMAIL — Email form to us now

PRINT — Print form and bring to your appointment

SAVE — Save form for later use

If you are experiencing problems with the buttons above, try:

1. Download the latest version of Adobe Acrobat Reader from the Adobe website at www.adobe.com

   OR

2. Save the form to your desktop, then email or print from there.