GUNNEDAH DENTAL CENTRE

SURNAME: _____ (MR/MRS/MISS/MS/DR):____

FIRST NAME: _____DATE OF BIRTH: ___/___/___

ADDRESS:_____

_____ POSTCODE: _____

POSTAL ADDRESS: _____

PRIVATE PHONE _____ BUSINESS PHONE: _____

MOBILE: _____ EMAIL: _____

OCCUPATION: _____

PERSON RESPONSIBLE FOR FEES (IF NOT SELF): _____

ADDRESS: _____

PURPOSE OF VISIT: _____

HEALTH FUND: _____

Have you had any of the following?

	Yes	No		Yes	No
Any heart conditions:	☐	☐	Allergies to Anaesthetics:	☐	☐
Blood pressure:	☐	☐	Allergies to Penicillin:	☐	☐
Artificial Joints:	☐	☐	Allergies to Medications:	☐	☐
Rheumatic Fever:	☐	☐	Allergies to Latex:	☐	☐
Circulatory Problems:	☐	☐	Anaemia or other Blood Conditions	☐	☐
Radiation Treatment:	☐	☐	Diabetes:	☐	☐
Excessive Bleeding:	☐	☐	Asthma:	☐	☐
Excessive Bruising:	☐	☐	Hepatitis: A B C D E	☐	☐
Ulcers (stomach):	☐	☐	Epilepsy:	☐	☐
Sinus Trouble:	☐	☐	Liver or Kidney Problems:	☐	☐
Tumour History:	☐	☐	Have you been in contact with HIV/AIDS?	☐	☐
Are you taking any drugs or medicines?				☐	☐

If yes please list: _____

_____

Do you have any heart condition? _____

If so please list:

_____

107 Barber Street. GUNNEDAH 2380
02 6742 0369

Have you had any of the following?

	Yes	No
Does your jaw "click" or hurt?	☐	☐
Do you feel you grind your teeth?	☐	☐
Have you ever had orthodontic treatment?	☐	☐
Do you wear a dental night guard splint?	☐	☐
Have you ever had periodontal (gum) treatment?	☐	☐
Have you ever had your bite adjusted?	☐	☐
Do you bite your lips or cheeks often?	☐	☐
Do you smoke?	☐	☐
Do you think you have occasional bad breath?	☐	☐
Do your gums ever bleed when you clean your teeth?	☐	☐
Do you experience sensitivity with hot/cold?	☐	☐
Do your teeth ever hurt when you bite hard?	☐	☐
Does floss ever tear between your teeth?	☐	☐
Does food get jammed between your teeth?	☐	☐
Is there anything else you would like us to know?	☐	☐

_____

_____

Who is your doctor? _____

Are you pregnant? _____

How long since your last dental appointment? _____

How often do you have dental examinations? _____

Previous dental x-rays were taken: Less than 1 year ago ☐ Longer than 1 year ☐

Consent for treatment

1. Upon consultation with my dentist, I hereby authorize the dentist or designated staff to take x-rays, study models, photographs and other diagnostic aids as deemed appropriate to make a thorough diagnosis.

2. Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anaesthetics and other medications as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand that I can ask for a complete recital of all possible complications.

4. I agree to be responsible for the payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient's Signature: ……. Date:……

Parent/Responsible Party's Signature:…… Relationship to Patient:…….

WE EXPECT AND APPRECIATE PAYMENT AT TIME OF SERVICE
WE ACCEPT MAJOR CREDIT CARDS, PERSONAL CHEQUES, EFTPOS AND CASH

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