southern dental care | smile by design

"The greatest recommendation of a person is their smile."
ARISTOTLE

In order to assist us to deliver optimal dental care specifically tailored to your needs, please take the time to answer the following questions to the best of your knowledge.

Medical History

Title: Dr Mr Mrs Ms Miss Master Sex: Male Female Date of Birth .....

Name: .....

Address: ..... Home Phone: .....

Email: ..... Work Phone: .....

Occupation (optional): ..... Mobile Phone: .....

Emergency Contact: ..... Phone: .....

How did you come by our practice? eg. ❒ referral, ❒ Internet ❒ other - If other please specify .....

What is the name of your health fund? .....

What is your Doctor's name and address: .....

Please tick yes or no to the following questions:

1. Have you been under the Doctor's care in the last six months? ❒ Yes ❒ No

   If so, what for? .....

2. Are you taking any drugs or medication? ❒ Yes ❒ No

   If so, what for? (Please list medications being taken including OTC/Herbal Remedies) .....

   .....

3. Are you allergic to penicillin or any other drugs? ❒ Yes ❒ No

   Please state .....

4. Have you ever had adverse reaction to any dental treatment (bleeding, fainting)? ❒ Yes ❒ No

5. (Women) Are you now pregnant? ❒ Yes ❒ No

6. Have you ever had any of the following? (please tick)

Y	N		Y	N	
❒	❒	Anaemia or Blood disease	❒	❒	High Blood Pressure
❒	❒	Radiation treatment	❒	❒	Heart disease / murmurs
❒	❒	Rheumatic Fever	❒	❒	Artificial Prosthesis (please specify) .....
❒	❒	Diabetes	❒	❒	Hepatitis ❒ A or ❒ B or ❒ C, ❒ Other .....
❒	❒	Arthritis	❒	❒	Cancer
❒	❒	Kidney or Liver Disease	❒	❒	Asthma
			❒	❒	Latex Allergy / Sensitivity

7. Do you have any cause to suspect that you may have been exposed to the AIDS or Hepatitis C virus, or that you are in a high risk group for exposure to these viruses? ❒ Yes ❒ No

8. Have you ever been seriously ill or been hospitalised for any condition not covered above? .....

9. Are you currently or previously been a smoker? ❒ Current ❒ Previous ❒ No

Please Turn Over

Dental History

1. Approximately when was your last dental examination? .....

2. What is the reason for your attendance today? .....

   If you have a toothache is the pain worsened by ❒ Hot ❒ Cold ❒ Pressure ❒ Sweet?

   Is the pain Constant ❒ Lingering after stimulus ❒ Slowly easing ❒ Present only when the tooth is stimulated ❒

3. On the below scale please indicate how nervous about dental treatment you are

   Very Nervous 1 |———|———|———|———|———|———|———|———|———| 10 Not Worried

4. Is there anything specific about dental treatment that bothers you? .....

5. Have you ever been treated for gum problems? ❒ Yes ❒ No

6. Have you ever noticed any unusual ulcers, lumps or swelling in your mouth? ❒ Yes ❒ No

7. Are you aware of grinding or clenching your teeth? ❒ Yes ❒ No

8. Are you aware of your jaw clicking or popping while eating or yawning? ❒ Yes ❒ No

9. Have you ever had pain in your jaw joints? ❒ Yes ❒ No

10. Are you happy with the appearance of your teeth? ❒ Yes ❒ No

11. Would you like more information on: ❒ Tooth Whitening ❒ White Fillings ❒ Implants ❒ Transforming your smile

12. What is important to you about dental care? .....

.....

Any other comments: .....

.....

.....

Patient's Signature: ..... Date: .....

Please ensure that your mobile telephone is turned off.

IF YOU HAVE ANY OTHER COMPLICATIONS OR RELEVANT MEDICAL HISTORY PLEASE DISCUSS WITH YOUR DENTIST.

All information contained in this document is confidential and subject to the Privacy Act.

PAYMENTS

Please note that you are required to settle your account after each visit.
THANK YOU FOR YOUR COOPERATION.