ALL INFORMATION WILL BE TREATED WITH STRICT PROFESSIONAL CONFIDENTIALITY

MR / MRS / MISS / MS / MASTER ***(Please Circle)*** DOB _____

FIRST NAME/S_____ SURNAME_____

POSTAL ADDRESS _____

_____. POST CODE_____

PHONE _____ MOBILE _____

OCCUPATION _____ WORKPLACE _____

WORK PHONE _____ EMAIL _____

NEXT OF KIN _____ PHONE _____

1. Who can we thank for referring you to My Dentist? _____
2. Are you a member of a private health fund for dental treatment? If yes, lease state _____
   Membership Number _____ No. next to Name_____
3. Are you eligible under Child Dental Benefits Scheme?_____Medicare No_____
4. Are you eligible under Metro North Oral Health Services Scheme?_____ Medicare No_____
5. Are you a DVA **Gold Card** Holder? If yes, card number please _____

MEDICAL QUESTIONNAIRE (Please tick if you have the following, circle where necessary)

High/Low Blood Pressure	☐	Diabetes: ***Type I or Type II***	☐	Anxiety/Depression	☐
Heart Murmur/ Other	☐	Asthma	☐	HIV/AIDS	☐
Heart Valve Disorder/Replacement	☐	Prolonged Bleeding	☐	Hepatis A, B, or C	☐
Pacemaker, *when was this placed*?	☐	Thyroid Disease	☐	Stroke	☐
Stomach/Intestinal Problems	☐	Cancer: ***Current or Past***	☐	Epilepsy	☐
Artificial Joints	☐	Osteoporosis/Bone Condition	☐	Lung Disease	☐
Liver Disease	☐	High/Low Cholesterol	☐	Reflux	☐
Kidney Problems	☐	Drug Addiction	☐	Sinus Issues	☐

Are you Pregnant or breastfeeding? _____ If Pregnant, when are you due? _____

Do you require antibiotic cover prior to dental treatment? ***(As advised by specialist)*** _____

Do you have any allergies? *(e.g., Latex, Penicillin, Sulphur, Local Anaesthetics)* _____

Do you smoke? ☐ Yes _____ Per Day ☐ No

If yes how interested are you in quitting? ☐ Very ☐ Somewhat ☐ Not Interested

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, please list, on average, how many per week: _____

Ladies, if you are using a contraceptive, p**lease read and initial**.

I understand that taking antibiotics may render contraceptives ineffective _____

Current List of Medications, including any medical injections in the last 6 months and contraceptives:

_____

Name of GP/Surgery Name: _____

DENTAL HISTORY:

Have you seen any of the following Specialists ***(please tick)***?

Orthodontist (braces) ☐ Periodontist (gums) ☐ Endodontist (root canal) ☐

Prosthodontist ☐ Oral Surgeon ☐

Are you currently using a CPAP or been diagnosed with sleep apnea? ☐

Have you ever had dental treatment performed under sedation? ☐

Do you ever feel anxious or nervous when visiting the dentist? ☐

Do you ever avoid smiling? ☐

Do you ever cover your mouth when you smile? ☐

Do you avoid smiling in photographs? ☐

Do you have chipped or worn-down teeth? ☐

Do you have stained or discoloured teeth? ☐

Do you have uneven teeth? ☐

Does food become jammed between your teeth? Where? _____

Do you floss? Never / hardly ever / monthly / weekly /daily

Do you use an electric toothbrush? Yes / No / occasionally

How long since your last dental visit?_____

Previous dental x-rays were taken [ ] Less than a year [ ] Longer than a year

Payment is required at the time of the appointment. For your convenience we accept cash, cheques, EFTPOS, and major credit cards. We have HICAPS (on your behalf we can claim directly from your dental insurance, only on the day of treatment).

I Understand that prior to treatment a full explanation of procedures involved will be given by the Dentist and/or his/her staff.

I consent to the performance of dental treatment, agreed to be necessary, and I am responsible for the fees associated with those procedures. I am aware payment is required at the time of treatment.

I understand that MyDentist require a minimum of two working days' notice should I need to reschedule an appointment *(Sufficient notice will enable this time to be offered to clients who may require it)* If I should fail to do so I may require to pre-pay for future appointments.

Patient Signature_____ Today's Date____/_____/_____

Parent/Guardian signature if patient is under 18: _____