Dental at Lake Haven

76 Goobarabah Ave

Lake Haven NSW 2259

Ph: 43926466 **Fax:** 49927565

Email: admin@dentalatlakehaven.com.au

Website: www.dentalatlakehaven.com

Dental at Kanwal

Suite C6, Kanwal Medical Complex

654 Pacific Hwy, Kanwal, NSW 2259

Ph: 43930020 Fax: 43930024

Email: admin@dentalatkanwal.com

Website: www.dentalatkanwal.com

Dear Patient,

Welcome to our Practice!

Please answer these questions as honestly as possible.

It will assist us greatly in our effort to provide the best dental treatment for you.

Patients Full Name: Mr/Mast/Mrs/Miss/Ms

Address

Suburb Postcode

Mobile Ph Work Ph Home

Date of Birth Occupation

Email Address

Person Responsible for Fees

Emergency contact – Name Contact No

What dental insurance or benefit do you have?

MEDICAL HISTORY

Who is your medical doctor? Ph No

Have you had any serious health problems during the past year?

Do you take prescribed medication regularly? Yes / No

If yes, please list names of all medications

Do you take blood thinning medication e.g. warfarin, aspirin?

Have you ever had excessive bleeding whilst in the dental chair?

Are you allergic to Penicillin or any other medication or Foods?

Do you or have you ever suffered from any of the following? (Please circle)

□ Heart/Vascular Disorder	□ Asthma / Reflux	□ Diabetes 1 or 2
□ High / Low Blood Pressure	□ Breathing difficulties	□ Epilepsy, seizures
□ Rheumatic Fever	□ Hepatitis A B C	□ Mouth Ulcers lumps, spots of concerns
□ Glandular fever	□ HIV / AIDS	□ Latex Allergy / milk allergy
□ Joint Replacement □ Liver / Kidney or lung Disease	□ Cancer □ Pacemaker / Defibrillator	□ please list other ailments below

Do you smoke? If so, how many per day?

(Women) Are you pregnant? If so, how many months?

DENTAL HISTORY

Are you concerned about or experiencing any of the following dental problems? (Please tick)

□ Sensitivity to hot or cold	□ Food trapping between teeth	□ Clicking/pain in the jaw joints
□ Staining of your teeth	□ Discoloured fillings	□ Roughness of existing fillings
□ Bleeding gums	□ Bad breath	□ Sensitivity when eating
□ Head/neck ache □Lumps or sores	□ Grinding/clenching of your teeth □ Existing crowns/bridges /Dentures	□ Numbness □ List other concern

What treatment do you require today?

How long since your last dental visit?

Does dental treatment make you nervous? □ No □ Slightly □ Moderately □ Extremely

Who referred you to our Practice?

CONSENT FOR SERVICES

- 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 **24 hours notice** if I need to cancel my scheduled appointment and **MUST** be **CONFIRMED 48 HRS prior** to your appointment.
- Many emergencies are turned away in the expectation that you will arrive, if this case arises, we may elect to give your appointment to others in pain/ or emergency situations, please understand

- I hereby authorise the dentist/hygienist to take x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis.
- I am aware that **payment is required** on the **day** of treatment.

Patient/Parent/Carer Signature Date

OFFICE USE ONLY

Updated By: **Signature:** **Scanned**