Dental at Lake Haven

Dear Patient, Welcome to our practice! Please answer these questions as completely as possible. It will assist us greatly in our effort to provide the best dental treatment for you.

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? …….. 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? …….....

Do You Or Have You Ever Suffered From Any Of The Following? (Please circle)

□ Heart/Vascular Disorder/Stroke	□ Asthma	□ Diabetes 1 - 2
□ High/Low Blood Pressure	□ breathing difficulties	□ Epilepsy, Seizures,
□ Rheumatic Fever	□ Hepatitis A B C	□ Mouth ulcers, Lumps or spots of concern,
=Glandular Fever	□ HIV/AIDS	
□ Liver , Kidney or lung Disease	= Cancer	□ Latex Allergy Milk Allergy
□ Joint Replacement	□ Pacemaker/ Defibrillator	=please list other ailments

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

(Women) Are you pregnant? ……..... 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	□ Grinding/clenching of your teeth	□ Existing crowns/bridges
=Lumps or Sores	=Numbness	or dentures

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 prior*** to your appointment.
  Many emergencies are turned away in the expectation you will arrive, if this case arises we may elect to give your appointment to others in pain/or emergency situations.
- 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: …….. Signature: ….....Scanned.....