25 Carisbrook Crescent
Lower Plenty, 3093
9435 6107
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Please print this form and bring this in with you on your first dental visit with us as this will help save time on your arrival. We value your privacy and all details will be kept strictly confidential. Please answer these questions as completely as possible. It will assist us greatly in our efforts to provide the best dental treatment for you.

Title: Mr, Mrs, Miss, Ms, Dr, Prof, (Other........) First Name: ______________________________

Surname:__________________________ Preferred Name: ______________________________

Address:____

Postcode:________________ City / Suburb:______________________________________

Home Ph:______________________________ Work Ph:___________________________

Mobile:___________________________ Preferred day time number : Home / Work / Mobile

Email__________________________@____________________________________

Date of Birth:_______/_______/_______

Occupation:_____________________________________ Employer: ________________________

Students: Full Time / Part Time School:____

Nearest Relative (not at your address) ____

Address:____

Phone Relative:____________________________

Person Responsible for fees____

What dental Insurance or Benefit do you have? ______________________________________

When was your last dental treatment?____

Please tell us how you discovered our surgery ______________________________________

Please turn over! >>>>> >>>>

What is the purpose of today's visit? (please circle)

Tooth ache	Unsatisfactory denture	Pain in face or jaw
Sensitive teeth (hot/cold)	Rapidly decaying teeth	Sounds (clicking) from jaw
Bleeding gums	Lost Filling - cavity	Difficulty/Discomfort when Chewing
Loosening teeth	Grinding/clenching of teeth	Discoloured teeth
Missing Teeth	Worn/Broken teeth	Bad Appearance
Bad Breath		

Other(please give details)____

____

Medical And Dental History Form

Have you **ever** experienced? Please Circle

Arthritis	Past / Present / Never	AIDS / HIV	Past / Present / Never
Allergies	Past / Present / Never	Rheumatic Fever	Past / Present / Never
Anaemia	Past / Present / Never	Liver Disease	Past / Present / Never
Angina	Past / Present / Never	Radiation Therapy	Past / Present / Never
Heart Murmur	Past / Present / Never	Asthma	Past / Present / Never
A Stroke	Past / Present / Never	Tuberculosis	Past / Present / Never
Epilepsy	Past / Present / Never	Diabetes	Past / Present / Never
High Blood Pressure	Past / Present / Never	Heart Ailment	Past / Present / Never
Low Blood Pressure	Past / Present / Never	Kidney Disease	Past / Present / Never
Hepatitis A/B/C/D	Past / Present / Never	Excessive Bleeding	Past / Present / Never
Osteoporosis	Past / Present / Never		

Any Other Previous Illness or Allergies? ____

Do You Have An Artificial Joint Replacement, Heart Valve Or Any Prosthetic Implant? Yes/No

Please give details____

Are You Presently Taking **ANY** Medications? Yes / No
Please List ____

____

____

Have You Ever Experienced Any Problems With Dental Treatment? Yes / No

Please give details____

Are You Pregnant? Yes / No _________weeks Do You Smoke? Yes / No

Who is your Doctor? ______________________________

Dr's phone no.____________________ Dr's address.______________________________

Signature: ______________________________ Date: / / 20___