FraserDental

*So that we can provide the very best care, please complete every question*

## SECTION ONE: YOUR DETAILS

First Names ..... Last Name .....

Title: Dr Mr Mrs Miss Ms Mst *(circle)* Date of Birth ..... / ..... / .....

Home Address .....Postcode .....

Mobile Phone ..... Home Phone .....

Email

Preferred contact methods: Home Mobile Text(SMS) Email *(please circle)*

Occupation ..... Employer .....

Who recommended you to us? I was referred by .....

**OR** I heard through: **Newspaper Google Facebook The Sign School Radio Friend**

**In case of an emergency, who should we contact?** Name .....

Phone ..... Relationship to you .....

Doctors Name (GP): ..... Practice: .....

**If you are under 18:** Parents Name ..... Parent's Phone .....

## SECTION TWO: YOUR DENTAL HISTORY

1. What is the reason for your visit today? .....
2. When was your last dental visit? .....
3. Who was your previous Dentist or Hygienist? .....
4. What do you use to clean your teeth at home? .....

5. Are any of your teeth sensitive to:

| | | |
|---|---|---|
| Hot | YES | NO |
| Cold | YES | NO |
| Biting/Chewing | YES | NO |

6. Have you ever had:

| | | |
|---|---|---|
| Orthodontics (braces) | YES | NO |
| Gum treatment | YES | NO |
| An injury to your teeth or jaws | YES | NO |
| A bad dental experience | YES | NO |
| Dental infections/abscess | YES | NO |
| Any teeth extracted | YES | NO |

7. Have you ever been aware of:

| | | |
|---|---|---|
| Sore or bleeding gums | YES | NO |
| Clicking or popping of the jaw | YES | NO |
| Jaw joint pain | YES | NO |
| Grinding/clenching | YES | NO |
| Head/neck/facial ache or pain | YES | NO |

8. Would you like information about:

| | | |
|---|---|---|
| Whitening your teeth | YES | NO |
| Straightening your teeth | YES | NO |
| Replacing missing teeth | YES | NO |
| Any other treatment..... | | |

**Please Turn Over →**

FraserDental

## SECTION THREE: YOUR MEDICAL HISTORY

1. Are you currently taking any medications? YES NO

   If **YES**, which medicines .....

2. Are you aware of any allergies or adverse reactions that you have? YES NO

   If **YES**, details: .....

3. Have you ever had, or been treated for any of these conditions?

| | | | | | |
|---|---|---|---|---|---|
| Heart Trouble | YES | NO | Stroke | YES | NO |
| High Blood Pressure | YES | NO | Sinusitis | YES | NO |
| Blood Disorders | YES | NO | Allergies | YES | NO |
| Anaemia | YES | NO | Diabetes | YES | NO |
| Rheumatic Fever | YES | NO | Hepatitis | YES | NO |
| Asthma | YES | NO | Arthritis | YES | NO |
| Bronchitis | YES | NO | Epilepsy | YES | NO |
| Gastric Reflux | YES | NO | Fainting or Dizziness | YES | NO |
| Stomach Ulcer | YES | NO | Latex Sensitivity | YES | NO |

4. Have you ever had, or are you being treated for any condition not listed above? YES NO

   If **YES**, please describe: .....

5. Do you believe yourself to be at risk from the HIV and/or Hepatitis virus? YES NO

6. Do you smoke? YES NO if **YES**, amount per day .....

7. Do you take any self prescribed and/or recreational drugs? YES NO

   If **YES**, details: .....

8. Women: Are you pregnant? YES NO if **YES**, number of months .....

## SECTION FOUR: OUR AGREEMENT

Please check this box if you do not wish to receive the practice newsletter with important information and updates □

**OUR COMMITMENT TO YOU:** At all times we will provide you the ***very best dental care available***. As a patient at our practice, your well-being is our first priority.

**YOUR COMMITMENT:** I agree that I am responsible for payment of all services on my behalf or on behalf of my dependents. I understand that payment is due at the time of treatment unless other arrangements have been finalised and a 15% fee will be added to outstanding accounts. If required for debt collection, I understand that a check of my credit history may be made, and/or my details may be passed to a third party. I understand that by making appointments with the practice I am agreeing to attend the appointments or to give a minimum of 24 hours notice of cancellation of appointments. If I fail to attend an appointment, a 'no-show' fee of $50 per half hour of the appointment may be charged.

*Signed*_____ *Date*____/____/20__ *Checked*_____