McIntosh Dental
Incorporating Lincoln Dental

Picture ☐
Entered ☐

To ensure that we can provide the very best care, please complete every question

SECTION ONE: YOUR DETAILS

First Names: Last Name:

Title: *(circle)* Dr Mr Mrs Miss Ms Master Other _____

Date of Birth: Gender:

Home Address:

Postcode:

Mobile Phone: Home phone:

Work Phone: Email:

Preferred contact method: *(circle)* Home Work Mobile Text Email

How did you find out about McIntosh Dental? *(circle)*

Newspaper Internet Newsletter Saw the Sign School Radio Yellow Pages Social Media Other_____

I was referred by (name)

Occupation: Employer:

In case of an emergency, who can we contact?

Name: Relationship to you:

Phone:

Doctors Name (GP): Practice:

If you are under 18:

Parents Name: Parent's Phone:

SECTION TWO: YOUR DENTAL HISTORY

What is the reason for your visit today? -

When was your last dental visit? -

Who was your previous Dentist or Hygienist? -

What do you use to clean your teeth at home?

Are any of your teeth sensitive to: Hot **YES** **NO** Cold **YES** **NO** Biting/Chewing **YES** **NO**

Have you ever had:			Have you ever been aware of?		
Orthodontics (braces)	YES	NO	Sore or bleeding gums	YES	NO
Gum treatment	YES	NO	Clicking or popping of the jaw	YES	NO
An injury to your teeth or jaws	YES	NO	Jaw joint pain	YES	NO
A bad dental experience	YES	NO	Grinding/clenching	YES	NO
Dental infections/abscess	YES	NO	Head/neck/facial ache or pain	YES	NO
Any teeth extracted	YES	NO			

Please Turn Over →

Would you like more information about:

Whitening your teeth	YES	NO
Straightening your teeth	YES	NO
Replacing missing teeth	YES	NO

Any other dental treatment: _____

SECTION THREE: YOUR MEDICAL HISTORY

Are you currently taking any medications? YES NO

If **YES**, which medicines:

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

If **YES**, details:

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

Heart Trouble	YES	NO	Stroke	YES	NO
High Blood Pressure Blood	YES	NO	Sinusitis	YES	NO
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

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

If **YES**, please describe: _____

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

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

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

If **YES**, details: _____

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*** in a modern friendly environment. As a patient at McIntosh Dental, your well-being is our 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. All costs incurred in the recovery of overdue funds including but not limited to debt recovery costs and legal fees will be added to the balance of your account. I understand that by making appointments with McIntosh Dental Centre I am agreeing to attend the appointments or to give a minimum of 48 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_____