**Welcome to The Dentists Hornsby!**

Thank you for giving us the opportunity to care for your oral health and smile. In order to provide high standard of care and treatment, please review and complete the following questionaire. It will be handled confidentially.

| Title: First Name: | Surname: |
|---|---|
| Date Of Birth: | Address: |
| Postcode: | Home Number: |
| Work Number: | Mobile Number: |
| Email: | Occupation: |
| Emergency Contact: | Private Health Fund:<br>Member Number: |
| If <18yrs, parent /responsible party: | |

**How did you hear about the Practice**? (Please circle)

Internet/Website Yellow Pages Walked past Letter Drop

Dentist/ Doctor: Other: Recommended by:

Is another member of the family a patient at our office:

**What is the main purpose of your visit today**?

Name of your **G.P**: Phone:
Address:

Have you had any of the following **Medical Issues**? please tick

| | | | |
|---|---|---|---|
| Heart Problems / Disease | Yes | Allergies to Anaesthetic / Latex | Yes |
| Blood Pressure | Yes | Allergies to Penicillin | Yes |
| Artificial Joints | Yes | Allergies to Medications | Yes |
| Rheumatic Fever | Yes | Sinus Problems | Yes |
| Heart Valve replaced/leaky | Yes | Anaemia or other blood problems | Yes |
| Circulatory Problems | Yes | Diabetes | Yes |
| Excessive Bruising /Bleeding | Yes | Asthma | Yes |
| Liver or Kidney Disease | Yes | Epilepsy | Yes |
| Radiation Treatment | Yes | Hepatitis A, B, C or D | Yes |
| Stomach Ulcers | Yes | Tuberculosis or CJD or HIV or AIDS | Yes |
| Cancer | Yes | Infectious Diseases | Yes |
| Sleep Apnoea | Yes | Dizziness/Fainting | Yes |
| Psychological Disorder | Yes | On Warfarin | |
| Are you Pregnant? | Yes | if so, what is your due date? | |

Are you currently taking any **medications**? Are you taking or have you taken any Bisphosphonate drugs?
If YES please provide details

Have you had any of the following **dental issues**? please circle

| | | | |
|---|---|---|---|
| Does your jaw click or hurt? | Yes | Do you smoke? | Yes |
| Do you feel you grind your teeth? | Yes | Bad Breath? | Yes |
| Orthodontic Treatment? | Yes | Bleeding Gums | Yes |
| Do you wear a guard at night? | Yes | Pain on bitting hard? | Yes |
| Sensitivity to hot or cold? | Yes | Food jamming between teeth? | Yes |
| Have you had gum Disease? | Yes | Problems flossing? | Yes |

**Other Notes or Concerns** you would like us to know about?

How long since your last dental visit?

How often do you have dental examinations?

Previous dental xrays were taken: Less than a year ago? Longer than a year ago?

**Consent for Treatment**

I hereby authorise the dentist or designated team to take x-ray, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand I can ask for a complete recital of any complications associated with treatment I may need. I agree to be responsible for payment of all sevices rendered on my behalf and on behalf of my dependents. I understand that payment is due at the end of service unless other arrangements have been made. I authorise that this information may be reviewed by team members of the dental practice.

Signature: Date:

Name: