



Full Name..... Date of Birth...../...../.....  
 Preferred name:..... Occupation.....  
 Address..... Suburb.....P/Code.....  
 Home Phone..... Mob.....  
 Email.....  
 Work Contact Number.....  
 How would you prefer to be reminded of your next appointment? Please Circle: SMS Email Phone  
 Name of person responsible for fees.....  
 Name of Emergency Contact.....Relationship.....Phone.....  
 Medical Doctor..... Phone.....  
 How did you find out about us?.....  
 Dental Insurance Company?.....  
 How will you settle your account today? Eftpos Visa MasterCard AMEX Cash

Have you ever had any of the following?			Please list any details/medications
Rheumatic Fever	Yes	No	
Epilepsy	Yes	No	
Asthma	Yes	No	
Tuberculosis	Yes	No	
Creutzfeldt Jacob Disease	Yes	No	
Diabetes	Yes	No	
Kidney or Liver Disorder	Yes	No	
Excessive Bleeding	Yes	No	
High Blood pressure	Yes	No	
Heart Ailment	Yes	No	
Hepatitis B or C	Yes	No	
HIV/AIDS	Yes	No	
Osteoporosis	Yes	No	
Cancer	Yes	No	
Do you smoke?	Yes	No	
Are you allergic to any drugs, medication or latex?	Yes	No	
Hip/Knee replacement	Yes	No	
Artificial heart valve or prosthetic implant	Yes	No	
Are you taking any Medications or tablets?	Yes	No	
Have you ever taken Fosamax, Actonel or Xgeva?	Yes	No	
Any other medical problems?	Yes	No	
Ladies: are you pregnant?	Yes	No	

Please tick if you would like to discuss any of the following?

- |                           |                    |                              |
|---------------------------|--------------------|------------------------------|
| Comprehensive examination | Difficulty Chewing | Grinding/ clenching of teeth |
| Cleaning of teeth         | Worn/Broken teeth  | Replacing missing teeth      |
| Tooth Ache                | Tooth Whitening    | Bleeding gums                |
| Sensitive teeth           | Crowding           | Lost filling / Cavity        |

Have you ever experienced any problems with Dental injections? NO.....YES.....

How long since your last dental treatment?.....

When you have completed this Pre-treatment history form and have answered **ALL** our questions please sign.

I have completed this Pre treatment history questionnaire to the best of my knowledge and understand that failure to make full disclosure may place **ME** at undue medical risk. I understand that notes radiographs or models may need to be sent to other medical practitioners to aid them in my treatment and consent to this. I also give my permission for the dental practice to use the above contact details to send me appointment and check up reminders.

Signature..... Date.....