

Swinburne Private Dental

- Welcome To Our Practice -

*Thank you for taking the time to complete this form truthfully and accurately.
This information enables us to provide you the best quality individual care.*

PLEASE PRINT CLEARLY

How did you hear about us? [please circle] Sign Google/Website Yellow Pages Facebook Leaflet

Were we recommended to you by family or friend? Name:

Title [please circle]: Mr Mrs Ms Miss Mst Dr Prof Rev Other:

Last Name: First Name:

Preferred Name: Date of Birth:/...../.....

Residential Address:

Suburb: State:..... Postcode:

Employment Address:

Suburb: State:..... Postcode:

Home Ph: Work Ph: Mobile:

Email Address:

Contact Preference [please circle]: Landline Mobile SMS Email

Person Responsible for Fees [if different from above]:

Do you have Private Health Insurance with dental cover? Yes / No

Name of Fund [if applicable]: Individual Member No: ...0.....

Occupation: Are you a Student? Yes / No

Emergency Contact Name:

Relationship To You: Phone:

GP Doctor/Clinic: Phone:

Do you presently have or have you ever had any of the following? [please circle]

Asthma	Yes / No	Intravenous Drugs	Yes / No
Arthritis	Yes / No	Jaw Pain/Clicking	Yes / No
Bleeding Disorder	Yes / No	Kidney Disease	Yes / No
Blood Pressure	Normal / High / Low	Latex Allergy	Yes / No
Blood Transfusion	Yes / No	Liver Disease	Yes / No
Bronchitis	Yes / No	Neck / Back Issues	Yes / No
Cancer	Yes/ No	Osteoporosis	Yes / No
Coldsores	Yes / No	Pacemaker	Yes / No
Dizziness/Fainting	Yes / No	Prosthetic Device.....	Yes / No
Diabetes	Yes / No	Reflux	Yes / No
Eczema	Yes / No	Rheumatic Fever	Yes / No
Epilepsy	Yes / No	Sinus Issues	Yes / No
Glaucoma	Yes / No	Stroke	Yes / No
Hayfever	Yes / No	Thyroid Issues.....	Yes / No
Heart/Vascular Disease	Yes / No	Ulcers	Yes / No
Hepatitis A, B, C	Yes / No	Other.....	
HIV/AIDS	Yes / No		
Smoker	Yes / No	How many per day?	Do you want to quit? Yes / No

*Female: Are you pregnant? Yes / No weeks

Are you presently being treated for any medical conditions? Yes / No [please list]:

Do you have any allergies? Yes / No [please list]:

Are you currently taking any medications? Yes / No [please list]:

What is the purpose of your visit today?

When did you last visit the dentist?

Are you a nervous dental patient?	Yes / No	
Do you brush your teeth daily?	Yes / No	How many times? per day
Do you floss your teeth daily?	Yes / No	How many times? per day
Do you use a mouthwash/rinse?	Yes / No	How many times? per day
Do your gums bleed easily?	Yes / No	
Are you happy with the colour of your teeth?	Yes / No	
Do you want to improve your smile?	Yes / No	

I hereby declare that I have read and understood all of the above and that the information given on this form is accurate to the best of my knowledge. I am fully aware that full payment is expected on the day of treatment, unless prior financial arrangements have been made, in accordance with Practice Policy. I recognise the importance of a truthful health history and understand that failure to make a complete disclosure may place me and/or others at medical risk. I give permission for my dental records to be shared with affiliated health providers where necessary for my dental treatment.

Signature ✕ Date: / /

Parent / Guardian Name [if applicable]: