

WELCOME TO OUR OFFICE

Please take your time to complete your medical and dental history questionnaire. It will assist us greatly in our effort to provide you the very best treatment for you. This information is kept strictly confidential

First Name: _____ Family Name: _____ DOB: _____

Street Address: _____ Suburb: _____ PCode: _____

Phone: Mobile: _____ Work: _____ Home: _____

Email: _____ @ _____ Occupation: _____

Dental Insurance [tick]: MED BUPA HCF TEACH Other

Preferred Appointment Confirmation: SMS Email Phone

How did you hear about us: Referral Website Signage Advert Google

Medical and Dental History

When was your last dental appointment? _____

When was your last panoramic/full mouth x-ray? _____

Would a visit to the dentist cause you anxiety? _____

If you would have concerns about your oral health, what would you most likely want to talk about?

Metal Fillings Tooth Shape

Root Canals Sensitive Teeth

Gaps/Spaces Your Smile

Missing Teeth Your Gums

Have you had serious health problems during the past year? If so, please indicate briefly the nature of your problems:

Have you had any allergic reactions to any treatment or medication, in particular to Penicillin / Antibiotics?

What medications are you currently on? _____

Name and contact of your GP: Dr _____ Phone: _____

Please note, payment is due on the day of treatment

Signature: _____ Date: ____/____/____

Please complete and bring with you