

Patient Information

Surname: _____
 Given Names: _____
 Title: _____
 Date of birth: _____
 Occupation: _____
 Address: _____
 Postcode: _____
 Phone: _____ Please tick your preferred contact
 Mobile: _____ for appointment
 Work Phone: _____ reminders
 Email: _____

Emergency contact person

Name: _____
 Phone: _____

Health fund information (if applicable)

Fund name: _____
 Line number: _____

Parent / Guardian details (if under 18)

Name: _____
 Address: _____
 Phone: _____

Referral information - How did you find us?

Internet Walk in Yellow Pages Family member Friend Other: _____

Medical history

Have you ever had, or do you suffer from, any of the following? Please tick those that apply:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Anemia / Blood disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Steroid Therapy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Stomach issues |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting disorder | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stress disorders |
| <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Gastric banding / Lap band | <input type="checkbox"/> Prosthetic | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bone Disease / Osteoporosis | <input type="checkbox"/> Heart disease / Murmur / Stent | <input type="checkbox"/> Prosthetic implant / Joint replacement | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Brain shunt / injury / surgery | <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Psychiatric condition | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Cancer / Chemotherapy | <input type="checkbox"/> Immune disorders | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Tumours |
| | | <input type="checkbox"/> Sinus problems | |

How do you rate your overall GENERAL HEALTH? Poor Fair Good Excellent

Are you currently taking any pills, medications, or supplements? No Yes → _____

Do you have any allergies to antibiotics, medications, or other substances? No Yes → _____

Have you had any serious illnesses in the past two years? No Yes → _____

Are you expecting to undergo any surgery or treatment in the next six months? No Yes → _____

Have you ever taken any medications for any bone disorder? No Yes → _____

Do you have any other medical conditions that you have not listed above? No Yes → _____

Do you smoke cigarettes or other recreational drugs No Yes → How many per day? _____

If applicable, please also answer the following questions:

Are you currently, or do you think you might be, pregnant? No Yes → Likely due date: _____

Are you currently breastfeeding? No Yes

Consent for contacting General Medical Practitioner

For the purposes of maintaining and collecting accurate information about your health and in accordance with our Privacy Policy, it may be necessary at times to be able to contact your Medical Doctor directly, in order to carry out your treatment safely and effectively.

I, the undersigned, give my Dental Practitioner at Hopkins Street Dental Surgery, permission to contact my General Practitioner or Specialist, if required, in the course of my dental treatment, to obtain or discuss issues that are relevant to my health.

I understand that this will be done in accordance with the Privacy Act 1988* and will be confidential.

Patient/parent/guardian signature: _____ Date: _____

GP name: _____ GP contact phone: _____

Dental history

If you are experiencing any of the following, please TICK those that apply:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Sensitivity to hot or cold | <input type="checkbox"/> Pain on biting | <input type="checkbox"/> Missing teeth | <input type="checkbox"/> Rough existing fillings |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Impaired ability to eat | <input type="checkbox"/> Worn / broken teeth | <input type="checkbox"/> Lost fillings |
| <input type="checkbox"/> Discoloured filling | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Tooth ache | <input type="checkbox"/> Crooked teeth |
| <input type="checkbox"/> Headache or neck ache | <input type="checkbox"/> Grinding or clenching | <input type="checkbox"/> Tooth decay | <input type="checkbox"/> Gaps between teeth |
| <input type="checkbox"/> Food trapping | <input type="checkbox"/> Loose or ill-fitting dentures | <input type="checkbox"/> Clicking or pain in the jaw | <input type="checkbox"/> Loose teeth |
| <input type="checkbox"/> Staining of your teeth | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Problems with previous dental treatment | <input type="checkbox"/> Ulcers / blisters / lumps |
| | | <input type="checkbox"/> Problems with existing crowns or bridges | |

Are you attending for a specific problem as listed above? No Yes → _____

How long ago was your last dental visit? 6 mths or less 1 yr Between 1-2 yrs 2 yrs Between 2-5 yrs 5 yrs or more

Does dental treatment make you feel nervous? Never Slightly Moderately Extremely

Are you satisfied with the appearance of your teeth? Yes No → _____

Have you had your wisdom teeth removed? Yes No

Please tick any of the following you use for daily oral health

<input type="checkbox"/> Non-fluoridated toothpaste	<input type="checkbox"/> Interdental brushes	<input type="checkbox"/> Electric toothbrush	<input type="checkbox"/> Toothpicks / Waterpik
<input type="checkbox"/> Fluoridated toothpaste	<input type="checkbox"/> Dental tape / floss	<input type="checkbox"/> Manual toothbrush	

Do you drink fluoridated water?
(*Town' or 'council' water is fluoridated, bottled or tank water typically is not) Yes No

How many times a day do you brush your teeth? 4 or more 3 2 1 I don't always brush daily

Consent for service

- I, the undersigned, to the best of my knowledge, have provided accurate information relating to my health and if any changes are required, I will notify the practice as soon as is practical.
- I consent to the performing of dental and surgical procedures agreed to be necessary or advisable and will assume responsibility for the fees associated with those procedures.
- I am aware that payment is made in the day of service.
- I understand that Tony Hill Dental requires at least 24 hours notice should I need to cancel my scheduled appointment and that a cancellation fee of \$95 may be charged

Patient/parent/guardian signature: _____ Date: _____