Welcome to Dentessence. Please complete the following form as accurately as possible, this will allow us to be able to treat you in a safe and efficient way.

Patient's full name: Dr Mr Mrs Ms Mst Miss.....

Address..... Post Code.....

Date of Birth..... Ph Home..... Ph Work.....

Mobile..... Email.....

Occupation..... Person responsible for Fees.....

How did you hear about Dentessence.....

Name of Private Dental Insurance (if any)?..... or ☐ No Dental Insurance

In case of emergency who should we contact?..... Phone.....

Patient's Doctor..... Phone.....

Medical Conditions: Please tick the boxes below if you have or ever had any of the following medical conditions.

- ☐ Heart disease
- ☐ Rheumatic fever
- ☐ Asthma
- ☐ Hepatitis A, B or C
- ☐ HIV/AIDS
- ☐ Creutzfeldt-Jakob Disease
- ☐ Tumors / Cancer
- ☐ Osteoporosis
- ☐ Headaches/Migraines
- ☐ Grinding/Clenching
- ☐ Artificial heart valve or pacemaker
- ☐ Artificial joint (hip, knee)
- ☐ High or Low Blood Pressure
- ☐ Diabetes
- ☐ Blood disorders
- ☐ Mouth ulcers
- ☐ Stroke
- ☐ Kidney disorders
- ☐ Chemotherapy
- ☐ Radiotherapy
- ☐ Bruise/Bleed easily
- ☐ Tuberculosis

Do you have any allergies? E.g. Penicillin, Latex.....

Please list all medication you are currently taking .....

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For Women: Are you pregnant? ☐ No ☐ Yes If Yes how many weeks?.....

Do you smoke? ☐ No ☐ Yes How many per day?.....

Dental History: Please answer the following questions to allow us to find out a little more about your dental health.

What is the reason for your visit today?.....

When was your last visit to the dentist? ..... Do you usually have regular dental check-ups?.....

How often do you brush and floss your teeth?.....

Are you happy with the appearance/function of your teeth? .....

- **I am aware that payment is required on the day of treatment.**
- **I understand that the practice requires at least 24 hours notice if I need to cancel my scheduled appointment and that a cancellation fee, at the discretion of the dentist could be incurred if I fail to do so.**

I have answered all the questions to the best of my knowledge. Should further information be required, the practice has my permission to request them from the respective health care provider. I understand that the information I have provided is important for the delivery of my dental treatment in a safe manner within this practice. I understand that this document will be treated in the strictest confidence by the practice.

....

Patient / Guardian Signature Date

39 Chute St, Diamond Creek, Vic 3089

Ph. 9438 5103 Fax. 9438 5203