WELCOME TO OUR OFFICE

A.R. DENTAL GROUP

JOONDALUP
CITY DENTAL

CANDLEWOOD
DENTAL CENTRE

Would you please be kind enough to answer the following questions.
All information will be treated with complete professional confidentiality

Ms / Miss / Mrs / Mr .....
(Surname) (First Name)

Date of Birth / / Marital Status S ❑ M ❑

Email .....

Address .....

Suburb ..... State ..... Postcode .....

Home Phone ( ) ..... Business Phone ( ) ..... Mobile .....

Best Phone No. for daytime contact .....

How will you be paying your account today? Cash ❑ Credit Card ❑ Eftpos ❑

Name of Employer .....

Occupation .....

Business Address ..... Phone ( ) .....

In Case of Emergency Call ..... Phone ( ) .....

Name and address of close relative (not living at your address) .....

..... Phone ( ) .....

Person Responsible for Account .....

Name of Private Health Insurance Fund .....

How did you hear about our practice?

Yellow Pages ❑ Google ❑ Our Website ❑ Radio Ad ❑ Word of Mouth ❑ Other Dentist Referral ❑

How long has it been since your last *Complete Dental Examination*? .....

.....

PLEASE TURN OVER

Do you drink Alcohol? ❑ Yes ❑ No

If Yes, How Often?

Are you happy with your smile? ❑ Yes ❑ No

Would you like to talk to us about tooth whitening? ❑ Yes ❑ No

General Health ❑ Excellent ❑ GOOD ❑ FAIR ❑ POOR

Doctor's Name Phone ( )

Are you Pregnant ❑ Yes ❑ No If yes, expected date

Do you Smoke? ❑ Yes ❑ No If yes, how many per day

Do you have any Allergy? (eg. Latex, Nickel) ❑ Yes ❑ No Detail

Are you allergic to any medications? (Including Antibiotic) ❑ Yes ❑ No Detail

Are you taking any medication ❑ Yes ❑ No

If yes, name of medication and concerns for which they are taken:

1. 2.

3. 4.

HAVE YOU EVER HAD					
Rheumatic Fever	❑ Yes	❑ No	Asthma	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No	Sinus Trouble	❑ Yes	❑ No
Heart Disease Surgery	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No
Cardiac Pace Maker	❑ Yes	❑ No	Stomach Ulcers	❑ Yes	❑ No
High or Low Blood Pressure	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No
Joint Replacement Surgery	❑ Yes	❑ No	Transplant Organ	❑ Yes	❑ No
Blood Disorders	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No
Prolonged Bleeding	❑ Yes	❑ No	Any Form of Cancer	❑ Yes	❑ No
Stroke	❑ Yes	❑ No	Radiation Therapy	❑ Yes	❑ No
Epilepsy	❑ Yes	❑ No	Bone Diseases/Osteoporosis	❑ Yes	❑ No
Nervous System Disorder	❑ Yes	❑ No	Bisphosphonate Therapy	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No	Thyroid Disease	❑ Yes	❑ No
			HIV/AIDS	❑ Yes	❑ No

If you have answered YES to any of the above please explain

Are you particularly nervous about dental treatment? ❑ Yes ❑ No

Do you normally have injections for your dental treatment? ❑ Yes ❑ No

How do you rate the overall condition of your mouth (on scale of 1[poor] to 5 [excellent])

1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑

What are you expecting from today's visit?

Future

Would you like to talk to us about Sleep Dentistry?

Intravenous Sedation	❑ Yes	❑ No	Inhalation Sedation (Happy gas)	❑ Yes	❑ No
General Anaesthetic	❑ Yes	❑ No	Oral Sedation	❑ Yes	❑ No

ALL INFORMATION WILL BE TREATED WITH COMPLETE PROFESSIONAL CONFIDENTIALITY.
I AGREE TO ACCEPT LIABILITY FOR ANY COST INCURRED SHOULD DEBT COLLECTION RECOVERY ACTION NEED TO BE TAKEN

DATE SIGNED