Photo	Drop your image here or click to upload
Title	
Gender	◯ Male ◯ Female
Last Name	
First Name	
Date of Birth	dd/mm/yyyy
Preferred Name	
Home Phone	
Mobile	
Work Phone	
Emergency Contact	
Emergency Phone	
Address	
Street Address	Enter a location
Suburb	Enter a location
Postcode	

State	
Email	
Occupation	
Company	
Health Fund	
HF Membership No.	#
Preferred Method of Contact	☑ Telephone ☑ SMS ☑ Email ☑ Letter/Mail

Medicare

Medicare No.	**# on card** **Valid to** mm/yyy
DVA No.	

Medical Doctor (GP) Details

Doctor's Name	
Provider Number	
Contact Number	
Street Address	Enter a location
Suburb	Enter a location
Postcode	

State

Referral No.

Referral Date

Medical History

Question	Answer	Details
Have you ever been hospitalised?	Yes / No	details
Are you taking any medications?	Yes / No	details
Are you under care of a doctor?	Yes / No	details
Do you smoke?	Yes / No	details
Have you had a joint replacement surgery?	Yes / No	details

Do you suffer from the following allergies?

To Drugs

Drug	Answer	Drug	Answer
Penicillin	Yes / No	Heparin	Yes / No
Meprobamate	Yes / No	Sulfonamide	Yes / No
Codeine	Yes / No	Barbiturate	Yes / No
Thiazide	Yes / No	Procaine	Yes / No
Iodine	Yes / No	Tetracaine	Yes / No
Insulin	Yes / No	Propoxycaine	Yes / No

Salicylates	Yes	No	**Benzocaine**	Yes	No
Opiate	Yes	No	**Procainamide**	Yes	No

To Dental Materials

General

Latex	Yes	No	**Hayfever**	Yes	No
Amalgam	Yes	No	**Food**	Yes	No
Nickel	Yes	No	**Animal**	Yes	No
Chromium	Yes	No	**Stings**	Yes	No

Other Allergies

Other	Yes	No	**details**

Have You Ever Suffered from

Epilepsy	Yes	No	**details**
Rheumatic fever	Yes	No	**details**
High or low blood pressure	Yes	No	**details**
Heart condition	Yes	No	**details**
Blood disease	Yes	No	**details**
Diabetes	Yes	No	**details**
Asthma	Yes	No	**details**
Haemophilia or prolonged bleeding	Yes	No	**details**
HIV/AIDS	Yes	No	**details**
Hepatitis	Yes	No	**details**

Antibiotics Cover

Do you need to take antibiotics before any dental treatment?

Yes No

details

Other Important Health Issues

Do you have any other important health issues?

Yes No

details

General Questions

How did you hear about us?

How do you feel about seeing a dentist?

How would you like to improve your smile?

- ☐ Improve Colour
- ☐ Add Height
- ☐ Add width
- ☐ Change Shape
- ☐ Replace old discoloured fillings
- ☐ Accept Doctor's suggestions

Other improvement

How long has it been since your last dental visit?

What is your main concern regarding your teeth?

Are there any matters of a confidential nature you wish to discuss in private? ☐

Click to sign and complete the Form