CLIFTON STREET **DENTISTS**

Welcome to our Practice

Thank you for taking the time to complete this form truthfully and accurately.
This information enables us to provide you the best quality individual care.

PLEASE PRINT CLEARLY

Title [please circle]: Mr / Mrs / Ms / Miss / Mst / Dr / Prof / Rev

Surname: .... Given Name: ....

Preferred Name: .... Date of Birth: ..../............../..............

Residential Address: ....

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

Home Ph: .... Work Ph: .... Mobile: ....

Email Address: ....

Contact Preference [please circle]: Landline Mobile SMS Email

Occupation: .... Work Place Suburb: ....

Company Name: ....

Person Responsible for Fees [if different from above]: ....

How did you hear about us? [please tick]

☐ **Signage** ☐ **Google/Website** ☐ **Yellow Pages** ☐ **Facebook** ☐ **Leaflet**

☐ **Family or Friend** **Name:** ....

Do you have Private Health Insurance with dental cover? Yes / No

Name of Fund [if applicable]: .... Individual Line No: ....

Emergency Contact Name: ....

Relationship To You: .... Phone: ....

GP Doctor/Clinic: .... Phone: ....

PTO

Do you presently have or have you ever had any of the following? [please circle]

Asthma	Yes / No	Intravenous Drugs	Yes / No
Arthritis	Yes / No	Jaw Pain/Clicking	Yes / No
Bleeding Disorder	Yes / No	Kidney Disease	Yes / No
Blood Pressure	Normal / High / Low	Latex Allergy	Yes / No
Blood Transfusion	Yes / No	Liver Disease	Yes / No
Cancer……………………………	Yes/ No	Neck / Back Issues	Yes / No
Cold sores	Yes / No	Osteoporosis	Yes / No
Creutzfeldt-Jacob disease	Yes / No	Pacemaker	Yes / No
Dizziness/Fainting	Yes / No	Prosthetic Device……………………	Yes / No
Diabetes	Yes / No	Reflux	Yes / No
Eczema	Yes / No	Rheumatic Fever	Yes / No
Emphysema	Yes/ No	Sinus Issues	Yes / No
Epilepsy	Yes / No	Stroke	Yes / No
Glaucoma	Yes / No	Tuberculosis	Yes / No
Hayfever	Yes / No	Thyroid Issues…………………………	Yes / No
Heart/Vascular Disease	Yes / No	Ulcers	Yes / No
Hepatitis A, B, C	Yes / No	Other……………………………………………………	
HIV/AIDS	Yes / No		

Smoker *Yes / No* How many per day? ……… Do you want to quit? Yes / No

***Female: Are you pregnant? Yes / No ………… weeks**

Are you presently being treated for any medical conditions? Yes / No [please list]: ……………………………

………

………

Do you have any allergies? Yes / No [please list]: ……………………………………………………………………

………

Are you currently taking any medications? Yes / No [please list]: ………………………………………………

………

What is the purpose of your visit today? ……………………………………………………………………………

When did you last visit the dentist? …………………………………………………………………………………

Are you a nervous dental patient?	Yes / No	
Do you brush your teeth daily?	Yes / No	How many times? ………… per day
Do you floss your teeth daily?	Yes / No	How many times? ………… per day
Do you use a mouthwash/rinse?	Yes / No	How many times? ………… per day
Do your gums bleed easily?	Yes / No	
Are you happy with the colour of your teeth?	Yes / No	
Do you want to improve your smile?	Yes / No	
Do you suffer from jaw/ muscle pain?	Yes / No	
Do you have sleeping issues? -Snoring	Yes / No	
-Sleep apnoea	Yes / No	

I hereby declare that I have read and understood all of the above and that the information given on this form is accurate to the best of my knowledge. I am fully aware that full payment is expected on the day of treatment, unless prior financial arrangements have been made, in accordance with Practice Policy. I recognize the importance of a truthful health history and understand that failure to make a complete disclosure may place me and/or others at medical risk. I give permission for my dental records to be shared with affiliated health providers where necessary for my dental treatment.

Signature ✖ ………………………………………………………………… Date: / /

Parent / Guardian Name [if applicable]: ……………………………………………………………………

All personal information and health records remain strictly confidential.