*Please answer the following questions as completely as possible, this will assist us in our efforts to provide you with the best possible dental treatment. All information will be treated with complete confidentiality.

LAKE MACQUARIE
DENTAL PRACTICE™

NAME: ________ ____ ___________________________
Title Given Names Surname

ADDRESS: ____

Post code: ____________________ **DATE OF BIRTH**: _____/ _____/_______ **SEX**: M / F

Email:
____

OCCUPATION: ______________________________________**EMPLOYER**: _____________________________

PHONE: H: ______________________ W: ___________________________ M: ____________________________

MEDICARE CARD or DRIVER'S LICENCE number: ____

Private Health Insurance provider: ____

Membership Number: __________________________________ **Series Number:** ________________

DVA Card Number____________________ **Who referred you to the practice?** ______________________

<u>Please tick the following boxes if you have had any of the following:</u>

Heart Condition	☐	Prolonged bleeding	☐
Heart Surgery/valves	☐	Radiation Therapy	☐
Rheumatic Fever	☐	Chemotherapy	☐
Epilepsy	☐	Artificial joints placed	☐
Asthma	☐	Thyroid problems	☐
Abnormal blood pressure	☐	Nervous Disorder	☐
Diabetes	☐	Hay Fever	☐
Hepatitis	☐	Other____	

Please list current medications: ____

____

Hospitalized or Operations in past: ____

Allergies – please specify e.g. Penicillin, Latex etc... ____
**Please make us aware of any previous adverse reactions you may have had with <u>any medications</u>*

If pregnant, expected date baby is due? ____

Do you smoke, if yes how many per day? _____

What is your main dental concern today? ____

Have you had any of the following?

Does your jaw click or hurt? ☐ Yes
Do you smoke? ☐ Yes
Do you feel you grind your teeth? ☐ Yes
Do you think you have occasional bad breath? ☐ Yes
Have you ever had orthodontic treatment? ☐ Yes
Do your gums ever bleed when you brush your teeth? ☐ Yes
Do you wear a night guard? ☐ Yes
Do you experience sensitivity with hot/cold? ☐ Yes
Have you ever had gum disease? ☐ Yes
Does floss ever tear between your teeth? ☐ Yes
Have you ever had your bite adjusted? ☐ Yes
Does food get jammed between your teeth? ☐ Yes
Do you bite your lips or cheek often? ☐ Yes
Do your teeth ever hurt when you bite hard? ☐ Yes

Other notes ____
____

How long since your last dental appointment? ______________________________

***Consent for treatment**

- I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anaesthetics', sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents.
- I understand that payment is due at the time of service unless other arrangements have been made.
- I authorise that this data may be reviewed by team members of the dental practice.
- I understand that the practice requires as minimum 24 hours' notice if I need to cancel my scheduled appointment and that a rebooking deposit of $68.00 may be required if I fail to do so.
- **WE DO NOT BULK BILL,** Thank you.

Patient signature: ____

Date: _______________

Parent/ responsible party's signature: ____________________________________

Relationship to patient: ____