Woodend Dental

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Welcome to our practice. Please take the time to answer all of these questions as completely as possible. This will assist us greatly in our effort to provide the best dental treatment for you. All information will be treated with complete professional confidentiality.

Personal Information

Surname……..…….....First Name ……..…… Title ……
Preferred name ……..... D.O.B…..…../…..…./….....….
Address ……..……..
……..……..
Phone Home: ……..…... Work: ……..……
Mobile: ……..... Email: ……..……..……
Occupation…….....……..……
Emergency contact
Name…….....……..……
Relationship to you …….....……..……
Address…….....……..……
……..……...
Contact Phone ……..…… Email: ……..……..
Person responsible for fees ……..……..……..
Do you have dental insurance benefits? ……..……..……
……..……
Please tell us how you discovered our surgery ……..……..……
……..……..

Medical History

Who is your medical doctor/specialist? ……..……..……
Address…… Phone No…….....……
Are you presently under the care of a medical doctor? ……..……
If yes, what condition is being treated? ……..……..……
Are you presently taking any medication? ……..……..……
If yes, what medications are you taking? ……..……..……
……..……..
……..……..
Have you ever had any allergic reaction to any medication? ……..……..……..
Have you ever been hospitalized or had any serious health problems during the past year?
……..……
If yes, what was the problem? ……..……..……
……..……..……..
Are you, or is there any possibility that you are pregnant? Yes No
If yes, approximately how many months? ……..……
Are you Aboriginal or Torres Strait descent? Yes No

Continued overleaf…

Do you have, or have you had any of the following (please circle):
Rheumatic fever or heart disease / Heart murmur / Congenital heart disease
Heart trouble / Heart attack / Stroke / Previous infective endocarditis
Pacemaker / Prosthetic or artificial heart valve, repair, replacement
Organ transplant
High blood pressure / Low blood pressure
Blood disease / Known bleeder / Taking a blood thinner
Hepatitis / HIV / Blood transfusion
Asthma / Respiratory problems / Tuberculosis
Diabetes / Thyroid condition
Arthritis
Allergy / Hypersensitivity
Epilepsy / Fits
Cancer / Chemotherapy / Radiation therapy
Bone disorders / Bone medications (bisphosphonates)
Osteoporosis
Prosthetic or Artificial joint(s)
Stomach problems / Kidney Disease
Do you smoke? Yes No If yes, how many per day? …….……
Other health problems not listed …….……
…….……

Oral Health History

My major concern for today's visit is …….……
…….……
When was the last time you received dental treatment? …….……..
Have you had any trouble with any previous dental treatment? …….……
Do you experience any of the following? (please circle):
Toothache / Swelling on your gum around a tooth
Sensitivity to Hot / Cold / Sweets / Biting pressure
Bleeding gums
Concern with your breath
Loosening teeth / Drifting teeth Missing teeth
Denture problems
Broken tooth / Lost filling / Decay (cavity)
Grinding / Clenching / Worn teeth
Jaw joint clicking / Jaw joint pain
Food catching between your teeth
Are you dissatisfied with the appearance of your teeth?
Discolouration
Crowding
Spaces / Gaps
Crooked teeth/ Chipped teeth
Other …….……..……

Patient's signature ……..……. Date…..…../…..…/…..…..