Welcome to Arthur St Dental Surgery

Following is a confidential questionnaire we would like you to complete
All information supplied is for use only in regard to dental treatment.

Name:...
Address:...
....

Phone:
(H)............................... (W).................................... (M)..................................
Preferred contact method:
□ Phone Call
□ SMS Text

Date of Birth......... /........... /............
Health Insurance Provider (if any)..
Occupation...
Name of Family Doctor...
Person responsible for fees (if not self)..

Full Fee Payment is required after your appointment

How were you referred to our practice?
□ Local Directory
□ Newspaper
□ Family (name)...
□ Friend (name)..

Have you ever had or are suffering from any serious illness......................
(if yes please specify)..

Heart problems	Yes □	No □	Excessive Bleeding	Yes □	No □
Rheumatic fever	Yes □	No □	Osteoporosis	Yes □	No □
Diabetes	Yes □	No □	Asthma	Yes □	No □
Hepatitis	Yes □	No □	HIV / AIDS	Yes □	No □
Reflux	Yes □	No □			

Are you taking any medication (drugs, pills etc.) at present (please specify)
....
....

Are you allergic to any medication (penicillin, codeine, sulphur, latex etc?)
If yes what...

Women
Are you pregnant Yes □ No □
(If yes, when is the baby due?)..

Dental Health History

Please tick if you have ever experienced or experience any of the following.

- ☐ Do you experience sensitivity with hot/cold?
- ☐ Does Floss ever tears between your teeth?
- ☐ Does food gets jammed between your teeth?
- ☐ Have you ever had tooth ache?
- ☐ Have you ever had a tooth break?
- ☐ Do you smoke?
- ☐ Do your gums ever bleed when you clean your teeth?
- ☐ Have you ever had periodontal (gum) treatment?
- ☐ Have you ever had braces?

Is there anything else you would like us to know about your teeth...

When was your last visit to a dentist...

How long since your last dental x-rays...

Consent for Treatment

1. Upon 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.

2. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand that payment is due at the time of service.

3. Please give us the courtesy of 48hrs notice if you need to reschedule. Your late cancellation may attract a fee of $50.00 and a deposit may also be required to secure your next dental appointment.

Signature..

Date...

We thank you for your co-operation.