Warner Lakes Dental
— Everyone Deserves a Beautiful Smile —

Warner Lakes Medical Precinct

1185 B Old North Road
Warner QLD,4500

Ph: 3448 0162

info@warnerlakesdental.com.au
Web: http://www.warnerlakesdental.com.au

First name: **(Ms, Miss, Mrs, Mr, Master, Dr, Prof)**	Surname:
DOB:	Address: Suburb:
Mobile:	Home/work phone:
Email:	Occupation:
Who can we thank for referring you:	Dental Health Fund:

What is your cultural background? _____

Do you Require an interpreter Yea No

Are you receiving any medical treatment at this present time? Yes No

Please list all your medications taken: _____

_____

Have you experienced any allergies or unusual effects from any tablets, injections or anaesthetic? Yes No

Details: _____

Do you require antibiotic prophylaxis before dental treatment? Yes No

Have you ever had any of the following? Please Tick

	3		3
Heart Problems		Anaemia or other blood disorders	
Blood Pressure		Diabetes	
Artificial joints		Asthma	
Rheumatic Fever		Hepatitis A B C D E (Please specify)	
Circulatory problems		Epilepsy	
Radiation Treatment		Liver problems	
Excessive bleeding		Kidney problems	
Excessive bruising		Sinus trouble	
Ulcers (stomach)		Cancers/Tumours	
Are you pregnant? (Women)			

Details of person to contact in an emergency:

Name: _____ Relationship: _____ Phone No: _____

Name of your GP: _____ Phone No: _____

Dental History

To enable the dentist to provide care specific to your individual needs, we would very much appreciate the following information:

Name and location of last dentist? _____

Approximate date of last dental visit? _____

Please circle:

Do you become *anxious* or *uncomfortable* when you are having dental treatment?	Yes	No
Are you a smoker?	Yes	No

Do you have teeth missing? If so, how many? _____

Do you have:	Implants	Dentures	Crowns	Bridges
Fillings	0	<10	<20	20+

Have you had any other specialist? treatment in the past?	Perio	Endo	Ortho	Oral surgery

Do you grind or clench your teeth?	Yes	No
Do you brush/floss daily?	Yes	No
Do you see a hygienist regularly**?**	Yes	No

How would you rate your smile on a scale of 1 to 10? (10 being perfect) _____

If you are currently experiencing pain, or have a dental concern, please answer the following questions:

Where abouts in your mouth?_____

If you have pain, is it constant or intermittent? _____

If intermittent, is it made worse by any of the following (please circle)	Hot	Cold	Sweet	Chewing

Are you taking pain medication	Yes	No

Do you have any of the following: (please tick)

Swelling		Issues with a bridge	
Loose tooth		Lost Crown	
Lost filling		Broken denture	
Broken Tooth			

How long has this been bothering you?_____

I understand that if I fail to give 48 hours' notice to cancel my appointment, that a fee may be charged. I agree to be responsible for payment of all services rendered on my behalf, and on the behalf of my dependents understand that this payment is due at the time of service unless other arrangements have been made.

Preferred me method of payment: EFTPOS Payment Plan Cash Medicare (Child Dental Benefit Scheme) DVA

Patient/responsible partys Name : _____ Date : _____

Parent/responsible partys signature : _____

Relationship to patient: _____