

# **BRUNSWICK HOLISTIC DENTAL CENTRE**

Welcome to our practice. We look forward to giving you the best service possible so that you can enjoy the benefits of optimal dental health.

Please complete this form primarily in order to alert us to any medical condition or medication that may interfere with the comfort or safety of your dental care. We will ensure that this information remains private and confidential.

## **Patient Details**

Title: Mr  Mrs  Ms  Miss  Master  Dr  Other: \_\_\_\_\_

Surname: \_\_\_\_\_ Given Name: \_\_\_\_\_

Preferred name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_ Post Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_ (we are trying to save paper and would appreciate being able to send letters such as recalls and newsletters via email.) **Is email an appropriate form of communication for you?** Yes  No

Medical Doctor details: \_\_\_\_\_ Are you covered by a Dental benefits plan? Yes  No

How did you discover our practice? \_\_\_\_\_ Occupation & Place of employment: \_\_\_\_\_

When was your last dental treatment? \_\_\_\_\_ Purpose of today's visit: \_\_\_\_\_

Please indicate your preferred method of appointment confirmation: SMS  Telephone

## **Medical History**

Do you have any present illness? No  Yes  If yes, please specify: \_\_\_\_\_

Are you currently taking any medication? No  Yes  If yes, please specify: \_\_\_\_\_

Are you allergic to any medication? No  Yes  If yes, please specify: \_\_\_\_\_

Women, are you pregnant? No  Yes  If yes, due date: \_\_\_\_\_

Do you smoke? No  Yes  If yes, how much: \_\_\_\_\_

### **Please indicate any of the following below that applies to you:**

- |  |  |
|--|--|
| <input type="checkbox"/> Angina  | <input type="checkbox"/> Epilepsy  |
| <input type="checkbox"/> Artificial Heart Valves/ Valve Defect                                     | <input type="checkbox"/> Heart Attack  |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Heart Murmur/ Heart Disease   |
| <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> Hepatitis A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| <input type="checkbox"/> Blood Pressure High <input type="checkbox"/> Low <input type="checkbox"/> | <input type="checkbox"/> HIV Positive  |
| <input type="checkbox"/> Bisphosphonates- Bone Disease   | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> Cancer Therapy  | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Cardiac Surgery/Pacemaker   | <input type="checkbox"/> Thyroid Disorder  |
| <input type="checkbox"/> Congenital Heart Defect   | <input type="checkbox"/> Infectious Diseases: _____  |
| <input type="checkbox"/> Diabetes Type 1 <input type="checkbox"/> Types 2 <input type="checkbox"/> | <input type="checkbox"/> Joint Replacement: _____  |

FOR YOUR COMFORT: Many people are still nervous about coming to the dentist. Whilst the improvements in techniques and anaesthetics have helped most people, you may still be apprehensive and wish us to take extra measures for your comfort. Please circle the number that indicates your present level of apprehension.

Completely at ease 0 1 2 3 4 5 6 7 8 9 10 Petrified

Is there anything you would like to discuss in private with the dentist: Yes  No

No accounts are kept in this office hence it is practice policy that payments are to be made on the day of treatment.

Patients Signature: \_\_\_\_\_ Date: \_\_\_\_\_