

BRUNSWICK HOLISTIC DENTAL CENTRE

Welcome

This form is primarily designed 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 will remain private and confidential.
Please complete this form and feel free to ask the receptionist for assistance if required.

Mr Mrs Ms Miss Dr Other _____

First Name: _____ Surname: _____

Preferred Name: _____ Date of Birth: _____ / _____ / _____

Address: _____

_____ Post Code: _____

Home Phone: _____ WorkPhone: _____ Mobile: _____

Email: _____ How did you discover our practice: _____

Occupation & Place of employment: _____

Medical Doctor Details: _____

Are you covered by a dental benefits plan? NO YES If yes, please specify: _____

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

MEDICAL HISTORY: There are some medicines and previous or present illnesses, which can modify or postpone some dental procedures. Please consider each question and circle correct answer.

Do you have any illness at present? NO YES If yes, please specify: _____

Are you currently taking any medication? NO YES If yes, please specify: _____

Do you have your medication with you? NO YES

Are you allergic to any medication? NO YES If yes, please specify: _____

Women, are you pregnant? NO YES If yes, due date: _____

SMOKING HISTORY – Please circle correct response:

Do you smoke? NO YES If yes, how much _____ Have you ever smoked? NO YES

FOR YOUR PROTECTION: You have our complete assurance that at this clinic, we practice the highest level of infection control for your well being and safety. Please feel free to discuss with us privately and confidentially, any concerns you may have.

Have you suffered from: (please tick all that apply)

Rhematic Fever	Diabetes	Bleeding disorders	Asthma
High/low blood pressure	Hepatitis B/C or HIV	Thyroid disorder	Other Diseases _____
Heart Disease	Epilepsy	Cancer therapy	_____

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: NO YES

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: _____