Welcome to CAMP HILL DENTAL

We respect your privacy and all records are kept strictly confidential. So we can ensure we are looking after your needs, please review and complete the following questionnaire:

SURNAME: (MR/MRS/MISS/MS/MASTER/DR)

FIRST NAME:

DATE OF BIRTH: / /

ADDRESS:

POSTCODE:

PRIVATE PHONE: BUSINESS PHONE:

MOBILE: EMAIL:

OCCUPATION:

BUSINESS ADDRESS:

PERSON RESPONSIBLE FOR FEES (IF NOT SELF):

DENTAL COVER: *with your health fund* No: 00, 01, 02, 03, 04, 05, 06

FUND NAME PLEASE CIRCLE NUMBER NEXT TO YOUR NAME

HOW DID YOU FIND OUR DENTAL PRACTICE?

☐ Family ☐ Friend ☐ Work Colleague NAME PLEASE ____________________ SO WE CAN THANK THEM.

☐ Yellow Pages ☐ White Pages ☐ School ☐ Website ☐ Sign ☐ Little Aussie brochure ☐ Coffee News

PURPOSE OF THIS VISIT?:

HAVE YOU ANY OF THE FOLLOWING? PLEASE TICK RELEVANT BOX "YES" or "NO"

	YES	NO		YES	NO
Any Heart Problems	☐	☐	Allergies to Anaesthetics	☐	☐
Any Blood Pressure Problems	☐	☐	Allergies to Penicillin	☐	☐
Artificial Joints	☐	☐	Allergies to Medications	☐	☐
Rheumatic Fever	☐	☐	Allergies to Latex	☐	☐
Circulatory Problems	☐	☐	Anaemis or other Blood Disorders	☐	☐
Radiation Treatment	☐	☐	Diabetes	☐	☐
Excessive Bleeding	☐	☐	Asthma	☐	☐
Excessive Bruising	☐	☐	Hepatitis A B C D E	☐	☐
Ulcers (stomach)	☐	☐	Epilepsy	☐	☐
Sinus Trouble	☐	☐	Liver or Kidney Problems	☐	☐
Tumour/Cancer History	☐	☐	Osteoporosis	☐	☐
Recent surgery	☐	☐	Risk of having AIDS/HIV etc	☐	☐

THE NAME OF YOUR PHYSICIAN SUBURB

LADIES: ARE YOU PREGNANT? YES ☐ NO ☐ DUE DATE: ________/________/________ NURSING: YES ☐ NO ☐

ARE YOU CURRENTLY TAKING ANY DRUGS OR MEDICINES? (INCLUDING ALL HERBAL/NATUROPATHIC SUPPLEMENTS)

PLEASE LIST

PLEASE COMPLETE OTHER SIDE

CAMP HILL DENTAL

HAVE YOU HAD ANY OF THE FOLLOWING?	OFTEN	SOMETIMES	NEVER
Does your jew 'click" or hurt	☐	☐	☐
Do you feel you grid or clench your teeth?	☐	☐	☐
Do you bite your lips or cheeks?	☐	☐	☐
Do you think you have occasional bad breath?	☐	☐	☐
Do your gums bleed when you brush your teeth?	☐	☐	☐
Do you experience sensitivity with hot/cold?	☐	☐	☐
Do your teeth ever hurt when your bite hard?	☐	☐	☐
Does food get caught between your teeth?	☐	☐	☐
Does floss ever tear between your teeth?	☐	☐	☐
How often do you floss?	☐	☐	☐
Do you wear a night guard?	YES	NO	
Have you had orthodontic treatment?	YES	NO	
Have you ever had periodontal (gum) treatment?	YES	NO	
Do you smoke?	YES	NO	______PER DAY

WHAT IS YOUR SECRET DENTAL WISH? ____

____

HOW LONG SINSE YOUR LAST DENTAL APPOINTMENT? ABOUT _____ MONTHS ABOUT _____ YEARS

PREVIOUS DENTAL X-RAYS WERE TAKEN? __________ LESS THAN 1 YEAR ☐ LONGER THAN 1 YEAR ☐ NEVER ☐

CONSENT FOR TREATMENT

1. I hereby authorise the dentist or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended trreatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
2. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetics agents embodies certain risk. I understand I can ask for a complete recital of any possible complications.
3. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.
4. I understand appointments not kept or cancelled within 24 hours may incur a non-attendance fee.

WE EXPECT AND APPRECIATE PAYMENT AT TIME OF SERVICE
WE ACCEPT ALL MAJOR CREDIT CARDS, PERSONAL CHEQUES, EFTPOS, CASH AND
HICAPS OR HEALTH FUND ELECTRONIC PAYMENTS: PLEASE REMEMBER YOUR HEALTH FUND CARD.

PATIENTS' OR PARENTS' SIGNATURE ____________________ DATE: / /

Thank you for filling out this form as it helps us design your dental treatment more accurately and successfully long term.