Welcome to CAMP HILL DENTAL

Camp Hill Dental
a reason to Smile

We respect your privacy and all records are kept strictly confidential. Please review and complete the following medical questionnaire to ensure the success of your oral health care and dental treatment.

SURNAME: _____MR/MRS/MISS/MS/MASTER/DR (please circle)

FIRST NAME: _____ DOB: ____/____/_____

ADDRESS: _____

_____POSTCODE: _____

MOBILE: _____EMAIL:_____

HOME Phone: _____BUSINESS Phone: _____

OCCUPATION: _____

Please specify your preference for confirming of appointments: SMS / Email / Phone

PERSON RESPONSIBLE FOR FEES (If not self): _____

DENTAL COVER (Health Fund): _____

PURPOSE OF THIS VISIT: _____

The name of your GP (doctor): _____SUBURB: _____

Emergency Contact & Phone Number:_____

Do you have or have you ever had any of the following medical conditions
(Please tick Yes or No box)

	Yes	No		Yes	No
Any Heart Complaints	☐	☐	Allergies to Penicillin	☐	☐
High or Low Blood Pressure	☐	☐	Allergies medications or foods etc	☐	☐
Heart Valve Disorder	☐	☐	Joint replacement surgery	☐	☐
Rheumatic Fever	☐	☐	Sinus Trouble	☐	☐
Anaemia/ other Blood Disorders	☐	☐	Asthma	☐	☐
High Cholesterol	☐	☐	Diabetes	☐	☐
Excessive Bruising/bleeding	☐	☐	Epilepsy	☐	☐
Stroke	☐	☐	Stomach or Digestive condition	☐	☐
Steroid Therapy	☐	☐	Hepatitis or Liver problems	☐	☐
Thyroid Disease	☐	☐	Risk of having AIDS/HIV etc.	☐	☐
Cancer/Tumour treatment	☐	☐	Osteoporosis	☐	☐
Radiation Treatment	☐	☐	Anxiety, depression	☐	☐
Recent surgery within 6 months	☐	☐	Sleeping disorders/sleep apnoea	☐	☐
Pregnant/breastfeeding	☐	☐	Smoking _____ per day		

Please list any other conditions: _____

Are you taking any medications including over the counter & any herbal/naturopathic supplements, such as glucosamine, fish oil, St John's Wort? PLEASE LIST

_____

Please complete PAGE 2

Have you had any of the following?	**Often**	**Sometimes**	**Never**
Do your gums bleed when you brush your teeth? …….	☐	☐	☐
Does your jaw "click" or hurt? …….	☐	☐	☐
Do you feel you grind or clench your teeth"? ……...	☐	☐	☐
Do you think you have occasional bad breath? ……	☐	☐	☐
Do you experience sensitivity with hot/cold? ……...	☐	☐	☐
Do your teeth ever hurt when you 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

What is your secret dental wish? _____

How long since your last dental appointment? Approx._____months Approx_____years

Previous dental x-rays were taken: less than 1 year ☐ longer than 1 year ☐ never ☐

How did you find our dental practice?

☐Family ☐Friend /Work Colleague NAME please _____so we can thank them.

☐Google search ☐Facebook ☐Website ☐Instagram

☐Yellow/White pages ☐ Referral cards ☐Sign ☐Other_____

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 treatment 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 risks. 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 CHEQUE, EFTPOS, CASH and HICAPS or Health Fund Electronic Payments: Please remember your health fund card.

Patient/Parent/Legal Guardian Signature_____Date____/____/20_____

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