Welcome to Canterbury Family Dental

Please answer the following questions to help us provide you with the highest standard of care.

Mr/Mrs/Ms/Miss/Other____

First Name:_____ Surname:_____

Home Address:_____

Suburb:_____ Post Code:_____ Date of Birth:_____/_____/_____

Phone (Home):_____ Mobile:_____

Occupation:_____ Email:_____

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Contact No: _____

How did you hear about our practice? _____

Private Dental Cover? Y / N Name of Health Fund_____

Card # _____ Ref # _____

Have you had any of the following? *(please circle)*

High blood pressure If yes, high or low? _____	YES / NO	Diabetes If yes, Type 1 or 2? _____	YES / NO
Heart / Valve Ailments	YES / NO	Rheumatic Fever	YES / NO
Low blood pressure	YES / NO	Thyroid problems	YES / NO
Kidney Disease	YES / NO	Pacemaker	YES / NO
Epilepsy	YES / NO	Aids / HIV	YES / NO
Bleeding Problems Please give details _____ _____	YES / NO	Cancer Please give details _____ _____	YES / NO
Stomach / Bowel Problems	YES / NO	Asthma	YES / NO

Please turn over →

Hepatitis YES / NO
If yes, please circle A B C

Do you smoke? YES / NO
If yes, how many per day? _____

Osteoporosis YES / NO

Tuberculosis YES / NO

Gastric Reflux YES / NO

Have you had any medical procedures or hospitalisations in the last 12 months? YES / NO

If yes, please give details:

_____

Do you have a milk protein allergy? YES / NO

Do you have a chlorhexidine allergy? YES / NO

Do you have allergies? YES / NO

Please list: _____

Please tick boxes if you are concerned with any of the following:

Discoloured teeth ☐ Sensitivity to hot/cold ☐ Frequent headaches ☐ Missing teeth ☐

Pain in face or jaw ☐ Dry mouth ☐ Bleeding gums ☐ Bad breath ☐

Grinding or clenching of teeth ☐ Pain in face or jaw ☐ Worn/Broken teeth ☐

Do you have any medical conditions the dentist should be aware of?
Please list: _____

Have you had surgery of any kind over past 12 months? YES / NO
If yes, what for? _____

Any current medications, drugs or tablets? YES / NO
Please list:_____

_____

Female patients: Are you pregnant? YES / NO

How often do you brush? Once a day ☐ Twice a day ☐ >Three times ☐

How often do you floss? Never ☐ Sometimes ☐ Every day ☐

I understand and agree that payment of all the treatments is due at the time of service.

Signature: _____ **Date:** _____

Thank you for your time and if you are happy with our care, please mention us to your family and friends