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CHESTNUT HILL DENTAL

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We are pleased to welcome you our practice. Please complete the form. The following information is necessary to enable us to provide you with your best dental care. All information disclosed is confidential.

PERSONAL DETAILS

First Name _____ Last Name _____ Age _____ DOB _____

Address _____

City _____ State_____ Zip Code _____

Phone (Home) _____ Phone (Mobile) _____

Occupation _____

Email Address _____

GP's Name and Location _____

Health Fund (if applicable) _____

If you are under 16, please name your parents/guardians _____

HEALTH DETAILS

Do you have, or have you ever had any of the following conditions?	**Yes**	**No**
Allergies (eg. Penicillin, sulphur, codeine, latex)	☐	☐
Arthritis	☐	☐
Artificial Joints (eg. Hip or knee replacement)	☐	☐
Bone Disorders (eg. Osteoporosis, Pagets disease, cancer of bone)	☐	☐
Cancer or tumour	☐	☐
Diabetes	☐	☐
Epilepsy or other Neurological Disorder	☐	☐
Fainting or dizziness	☐	☐
Hepatitis B or C	☐	☐
HIV/AIDS	☐	☐
Heart Problems (eg. Heart attack, angina, stroke, murmur)	☐	☐
Heart Surgery (eg. By-pass, valve replacement, pacemaker)	☐	☐
High or low blood pressure	☐	☐
Kidney or liver disease	☐	☐
Mental health issues	☐	☐
Radiation to head or neck	☐	☐
Respiratory problems	☐	☐
Sinus problems	☐	☐
Have you ever taken a bisphonate? (eg. atonel, zometa, fosamax etc.)	☐	☐
Do you bruise or bleed easily after injury?	☐	☐
Do you smoke or use other forms of tobacco?	☐	☐
Are you, or suspect you may be pregnant?	☐	☐

List all medication or tablets you currently take _____

_____

Is there anything else you can tell us about your general health? _____

YOUR DENTAL HISTORY

What is the reason you have come to see me today? _____

How long is it since you have seen a dentist? _____

How long has it been since you have had dental x-rays? _____

	Yes	No
Does food catch regularly in particular places between your teeth?	☐	☐
Do your gums bleed when brushing?	☐	☐
Are any of your teeth loose?	☐	☐
Are any of your teeth sensitive to hot, cold, pressure or tooth brushing?	☐	☐
Are you aware of grinding or clenching your teeth?	☐	☐
Do you have clicking or pain in the jaw joints?	☐	☐
Do you snore or have sleep apnoea?	☐	☐
Is there anything you dislike about the appearance or colour of your teeth?	☐	☐
Have you ever seen a Dental Specialist? (eg. Periodontist, Endodonist)	☐	☐
Have you had your wisdom teeth removed?	☐	☐

Do you want your treatment at this surgery to involve:	**Yes**	**No**
Examination of your teeth and mouth	☐	☐
Relief of pain today only, no further treatment or advice	☐	☐
Repair of teeth as required	☐	☐
Regular follow up, cleaning and preventative services	☐	☐
Consultation with you as to your treatment needs	☐	☐

Whom should be thank for recommending you to our surgery? _____

What are your greatest concerns and needs for your dental treament? _____

_____

CONSENT FOR SERVICES

- I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated and I will assume responsibility for the fees associated with these procedures.
- I understand that the practice requires at least 24 hours notice if I need to cancel my scheduled appointment and that a cancellation fee may apply.
- I am aware that payment is required on the day of treatment.
- We provide a courtesy to our patients a preventative recall program that offers a call service if you have not been to the practice in 6 months.

_____ _____

Patient Signature **Date of Signature**