Fletcher Dental Care

Mr/Mrs/Miss/Ms/Dr/Master

Surname:		**Given Names:**	
Date of Birth:		**Occupation:**	
Phone (H) **Phone (W)** **Phone (Mobile)** Please tick preferred contact method		**Home Address:**	

EMAIL ADDRESS_____

Health Fund(name)	**Patient (number)**	**Member card number**	

How did you find out about us?

○ **Internet** ○ **Walked past** ○ **Local Paper** ○ **Word of Mouth** ○ **Medical Practice**

○ **Patient** _____ (please provide name so we can thank them)

MEDICAL HISTORY

Name of GP: **Phone:**		**Address:**	

Emergency Contact_____

Please tick if you have ever had the following:

○ **Anaemia**	○ **Fainting**	○ **Pacemaker**
○ **Artificial Joints**	○ **Glaucoma**	○ **Radiation Therapy**
○ **Asthma**	○ **Heart Disease**	○ **Respiratory Problems**

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○ **Blood Disease**	○ **Heart Murmur**	○ **Rheumatic Fever**
○ **Cancer**	○ **Hep A,B or C**	○ **Sinus Problems**
○ **Dizziness**	○ **Jaundice**	○ **Stroke**
○ **Epilepsy**	○ **Kidney Disease**	○ **Tuberculosis**
○ **Excessive Bleeding**	○ **Liver Disease**	○ **Tumours**
○ **Diabetes**	○ **HIV/AIDS**	○ **Psychological Disorders**

Are you taking any medications? ○ **Y** ○ **N**
(list)_____

Do you have any allergies? (list)_____

DENTAL HISTORY

Do you experience any of the following?

○ **Sensitivity hot/cold**	○ **Food traps**	○ **Clicking/Pain in jaw**
○ **Grind/Clench**	○ **Bleeding gums**	○ **Bad breath**

Are you concerned about or experiencing any of the following?

(Please tick as many as applies)

○**Sleep Apnoea**	○**Gaps between teeth**	○**Teeth cleaning methods**
○**Existing crown/bridge**	○**Your smile**	○**Discolouration of teeth**
○**Crooked teeth**	○**Silver fillings**	○**Missing teeth**
○**Abscess**	○**Previous dental treatment**	○**Existing denture**

What is the Purpose of your visit today?

How long since your last dental visit?

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Have you had dental x-rays in the last 12months? **Yes ○** **No ○**

Consent for treatment: I hereby authorise the dentist or designated team to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed on by me. I agree to the use of anaesthetics, sedatives, and other medication as necessary. I understand that using anaesthetics agents embodies certain risks. I agree to be responsible for payment of all services rendered on my behalf and behalf of my dependants. I understand that payment is due at time of service unless other arrangements have been made. I authorise that this data may be reviewed by team members of the dental practice.

Patient Signature: **Guardian Signature:** **Date signed:**