It is important the details about your medical history as these could affect the success of your dental treatment. The information you provide is confidential and will be handled in accordance with the ADA policy.

Title: Mr Mrs Miss Master Ms Dr

Given Names:

Address:	**Suburb:**	**Post Code:**
Home Number:	**Mobile:**	**Work Ph:**
Email:	**Occupation:**	**Employer:**

How did you find us: family, friends, Google, referred by, other?

In case of emergency:	Name:	Phone:
Your GP:	Name:	Phone:

Private Health Fund with Dental Cover: Yes / No

If so, which Fund?

What would be a good outcome from today's visit?

Please tick all applicable conditions that apply to you:

Heart Murmur	Diabetes	High/Low Blood Pressure	Rheumatic Fever
Anaemia	Artificial Knee/Hip/ankle	Pace Maker	Excessive Bleeding
Steroids Therapy	Nervous Condition	Heart Condition	Epilepsy
Thyroid Problems	Drug Addiction	Asthma	Stroke
Hepatitis A B C	HIV	Osteoporosis	Cancer
Radio/Chemotherapy	Tuberculosis	Drug Addiction	Drink Alcohol
Pregnancy/weeks	Smoke/how many per day		

Allergies (latex, penicillin, etc.)

Are you taking any medicines and what are they?

Please tick all applicable health conditions that apply to you:

I snore	I Have had Orthodontic Treatment
I suffer from regular headaches	My teeth hurt when I bite hard
My jaw “clicks” or hurt	I have bad breath
I wear a dental night guard	My gums bleed when I clean my teeth
I bite my lips or cheeks often	I have had gum specialist treatment

I have sensitive teeth eg: sensitive to cold and hot

Consent for treatment

1. I hereby authorise the dentist to take r-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis, after being consulted.
2. 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.
3. I agree to the use of anaesthetics and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made.

Thank you for your assistance

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Patient/Guardian/Carer Signature **Date**