Mount Waverley Smiles

Title:________ First Name:______________________ Surname:______________________________ DOB: ____/____/____

Phone:_________________________ Mobile:_________________________ Email:______________________________

Address:____ Post Code:________________

Emergency Contact:____ Phone:_________________________________

Person responsible for fees: Myself / Other

If Other: Name:____ Phone:_________________________________

Do you have Private Dental Insurance? Yes/No Name of Fund:____

How did you find out about us?:____

Have you had any of the following?

	Yes	No		Yes	No
Any Heart Problems	☐	☐	Asthma	☐	☐
Heart Valve Replacement	☐	☐	Kidney Disease	☐	☐
Rheumatic Fever	☐	☐	Excessive Bleeding or Bruising	☐	☐
Artificial Joints	☐	☐	Bone Disorders or Diseases	☐	☐
High Blood Pressure	☐	☐	Epilepsy	☐	☐
Ulcers (Stomach)	☐	☐	Depression/Anxiety	☐	☐
Reflux	☐	☐	Tumor History	☐	☐
Diabetes	☐	☐	Allergy to Latex	☐	☐
Thyroid Problems	☐	☐	Do you smoke?	☐	☐
Hepatitis	☐	☐	Are you pregnant?	☐	☐
HIV	☐	☐			

Doctor (GP):____ Phone:____________________________

Do you have any allergies to penicillin or other medications?

If so please list:____

Are you currently taking any drugs or medication?

If so please list:____

Have you ever had problems with dental treatment?____

How long since your last dental visit?____

Is there anything else you would like us to know?____

I have completed the questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place me at undue medical risk. I understand that notes, radiographs (xrays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give my permission for the practice to use the above contact details to send me appointment and checkup reminders.

SIGNED:____ DATE:_________________________

On future visits any changes to the above should be advised