MEDICAL AND DENTAL EVALUATION FORM

Personal Details

(Dr/Ms/Mr/Mrs/Miss/Other)……………… **SURNAME**: ………………………………………………………

FIRST NAME: ……………………………………………Preferred Name:…………………………………

Date of Birth: ……………………………………………Occupation…………………………………………………

Postal Address: ……………………………………………………………………………………………………….

……………………………………………………………………………………………Postcode………………………….

Mobile…………………………………………………………Home phone………………………………………….

Work Phone………………………………….Email Address: …………………………………………………

Emergency contact……………………………Phone…………………………Relation…………………………

Person responsible for account/fees…………………………………………………………………………

Who is your Medical Practitioner (GP)?...

Address…………………………………………………………………………Phone……………………………….

Whom we may thank for referring you to our practice?

( ) Word of Mouth ( ) Google ( ) Instagram ( ) Facebook ( ) External Signage
( ) Recommended by ……………………………………………..

Are you covered by Dental Benefits (Private Health cover)? Yes/No…………………………….

If so, which………

How long since you had dental treatment? ....

Have you had any serious illness or major operations? Please give details……………………
………
………
Do you have any allergies? Please List…………………………………………………………………….

Do you have or have you suffered from any of the following;
( ) Heart trouble ( ) Heart Murmur ( ) Heart Valve problems ( ) Rheumatic fever
( ) Stroke ( ) Epilepsy ( ) High Blood pressure ( ) TB
( ) Asthma ( ) Diabetes ( ) Any Bleeding disorders ( ) Kidney problems
( ) Sinus trouble ( ) Tumours ( ) Hepatitis/Liver ( ) HIV/AIDS
( ) Any other illness; if yes, specify here…………………………………………………………………

Are you taking any medication at present? Please list…………………………………………………
………

Have you ever had chemotherapy or radiotherapy? If "YES", please give details…………
………

For Women – Is there any chance that you are pregnant at the moment? Please remember to inform us if you are in future. **Yes/No**

Have you experienced (please tick)
( ) Difficult extractions ( ) Unfavourable reactions to anaesthetics

Do you smoke? **Yes/No**

Please tick:
( ) Are you aware of any excessive clenching or grinding of your teeth?
( ) Do you ever wake in the morning with an increased awareness of your teeth/Jaws?
( ) Do you have any soreness or noises in your jaw joint?
( ) Have you previously worn a night guard?
( ) In your opinion, have your teeth worn down and/or become discoloured?
( ) Are you happy with the appearance/colour of your teeth?
( ) How would you rate your smile now (rate out of 10)?
1 2 3 4 5 6 7 8 9 10 (circle your response)
( ) What are your expectations for your new smile?
1 2 3 4 5 6 7 8 9 10 (circle your response)
( ) Do you have any loose teeth?
( ) Do your gums bleed when you clean your teeth?
( ) Do you feel you have bad breath?
( ) Have you had previous gum health problems?

WE REQUIRE AND APPRECIATE PAYMENT AT THE CONCLUSION OF EACH APPOINTMENT.

If you are unable to attend your scheduled appointment, we require 2 business day notice otherwise you may incur a late cancellation fee. Extenuating circumstances will be considered.

Date………………………………………………….Signature……………………………………………………