# Patient Information Form

**It is important for us to know how you heard about our practice – please tick**

| | | | |
|---|---|---|---|
| **Out Front shop signage (A-frame)** | | **T.V** | |
| **Facebook** | | **Phonebook** | |
| **+ Radio** | | **Website** | |

**Or can we thank someone personally for referring you to our practice:** _____

**TITLE: (Please circle) Ms, Miss, Mrs, Mr, Master DATE OF BIRTH:** _____ **OCCUPATION:** _____

**FIRST NAME:** _____ **LAST NAME:** _____

**ADDRESS:** _____ **SUBURB:** _____ **POSTCODE:** _____

**PHONE NO.'s (H):** _____**(Work):** _____ **(Mob:)**_____

**Email address:** _____

**Private Health Fund:** _____ **Name of your Doctor/Medical Centre:** _____

**Emergency contact person:** _____ **Contact No:** _____

**I understand that photographs may be taken and used as part of my dental record and to assist my dentist during treatment**

**Please Circle:**

**Do you normally require antibiotic cover before dental treatment?** **Yes / No**

**Have you had any abnormal reactions to local/general anaesthesia?** **Yes / No**

**Do you have any other known allergies to food/dust/medication or latex?** **Yes / No**

**If yes, please list:** _____

**Do you smoke?** **Yes / No**

**Are you pregnant?** **Yes / No / N/A**

**Are you currently being treated by a Doctor?** **Yes / No**

**Do have a current medical condition?** **Yes / No**

**If yes, please List:** _____

**Are you taking any prescription or other medications at present?** **Yes / No**

**If yes, please list:** _____

**Have you been hospitalised for a serious illness in the past 12months?** **Yes / No**

**Do you have any missing teeth?** **Yes / No**

**Do you experience bleeding gums?** **Yes / No**

**Can you tell us your brushing and flossing habits:**

**I usually brush: 1 x a day ☐ 2 x a day ☐ more than 2 times a day ☐**

**I usually floss: 1 x a day ☐ 2 x a day ☐ more than 2 times a day ☐**

**How often do you generally visit a dentist? 6 monthly ☐ Annually ☐ Only when you have a concern ☐**

**Signature:** _____ **Parent/Guardian Signature:** _____ **Date:** _____

It is important to know details about your medical history as this could affect the success and safety of your dental treatment.
**All information provided is totally confidential and will be handled in accordance with our Privacy Policy.**