Jannali Dental Care

72 Railway Crescent, Jannali NSW 2226

Pre-Treatment Details:

To provide you with treatment of a high standard, it is necessary to have the following information which will be handled confidentially. Please fill in the following details completely.

Surname: _____ **First Name**: _____ **Gender:** _____
Home Address: _____
Postcode: _____ **Home No. :** _____ **Medicare Card:** _____ **IRN** __
Mobile _____
Email Address: _____ **GP:** _____
DOB: _____
Occupation: _____ **Emergency Contact:** _____
Private Health Insurance: _____ **Private Health Insurance No**._____ **IRN** __

Who can we thank for referring you to us? Circle all that apply:
Friends / Family / Facebook / Google / Pharmacy Ad / Other: _____

Medical History: (Please Circle)

Rheumatic Fever: Y / N **Anaemia:** Y / N **High Blood Pressure:** Y / N **Diabetes:** Y / N
Hyperthyroidism: Y / N **Asthma:** Y / N **Excessive Bleeding:** Y / N
Liver Disease: Y / N **Hepatitis:** Y / N **Heart Disease:** Y / N

Are you an Intravenous drug user Y / N
Do you require antibiotic therapy for any condition prior to undergoing dental treatment? Y / N
Please specify: e.g. joint replacement _____
Are you allergic to any drugs or antiseptics (e.g. penicillin)? Please specify: Y / N
_____
Have you had any other serious illnesses or accidents in the past? Y / N
Please specify:
If pregnant, please state how many months: _____
Do you smoke? Y / N
Do you have any other medical conditions we need to know about?
Please specify_____
Are you currently on any medication? (**please specify on back of form)** Y / N

Dental Information:

If you will be kind enough to answer the following questions it will help us to help you more.

Is there anything in particular you want the dentist to look at today? Y / N
How long has it been since your last dental check-up? _____
Do you like the appearance of your teeth /your smile? Y / N
Do you have spaces that you don't like to look at? Y / N
Would you like whiter teeth? Y / N
Do you like the shape of your teeth? Y / N
Are your teeth chipped? Y / N
Are there any old fillings or dental work that you don't like to look at? Y / N
What would you most like to change about the appearance of your teeth? _____
Do your gums bleed when you brush your teeth? Y / N
Do you play contact sports? Y / N

By signing this form you hereby agree and acknowledge that: (i) you have accurately completed this new patient/medical history form to the best of your knowledge; (ii) you consent to any treatment agreed upon, to be carried out by the dentists and their staff; (iii) you are responsible for payment of all services rendered on your behalf and on behalf of your dependents; (iv) payment is due at the time of service unless other arrangements have been made; and (v) your dentist may take images of your teeth both before and after your treatment. These images may be used in a practice portfolio to showcase examples of dental work to other patients (your identity will remain anonymous).

Sign: _____ Date: _____