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**: _____ **Title:** _____ **DOB**: _____
Occupation: _____ **Home Phone:** _____ **Mobile:** _____
Home Address: _____ **Postcode:** _____
GP Name: _____ **Contact No:** _____
Email Address: _____
Emergency Contact Name: _____ **Emergency Contact Number:** _____
Private Health Insurance Provider: _____ **Member No**: _____ **Ref No:** _____
Medicare Card No:_____ **IRN:** _____

Who can we thank for referring you to us? Friends/Family/Facebook/Google/ Pharmacy Ad

Medical History: MUST CIRCLE Y OR N

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** Heart Disease: **Y / N**
Liver Disease: **Y / N** Hepatitis: A, B, C **Y / N**

Do you require injections e.g (Prolia) for any ongoing medical conditions? **Y / N**
Do you require antibiotic therapy for any condition prior to undergoing dental treatment? **Y / N**
Please specify: _____
Are you allergic to any medications or antibiotics (e.g. penicillin)? **Y / N** Please specify: _____
Have you had any other serious illnesses or accidents in the past? **Y / N** Please specify: _____
Covid Vaccine Status _____
If pregnant, please state how many months: _____
Do you smoke? **Y / N**
Do you have any other medical conditions we need to know about? **Y / N**
Please specify_____
Are you currently on any medication? (Please specify) **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 you want the dentist to look at today? **Y / N**
How long has it been since your last dental check-up? Please Specify: _____
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: _____