WELCOME TO

CROWS NEST DENTISTS

Your information collected is private and confidential. Please do not hesitate in supplying accurate information as the following details we obtain are vital for your treatment in this practice.

Title _____ Surname _____ Given names_____

Date of Birth _____/_____/_____. If under 18 years of age parent/guardian's name is _____

Home address _____ Business address _____

Suburb_____ Postcode _____ Suburb_____ Postcode _____

Tel. Home _____ Tel. Business _____

Mobile _____ Email _____

Person responsible for fees _____

Were you referred or recommended to us? **YES** / **NO** If so, by whom_____

If not, how did you find/learn about us? (please specify) _____

Do you have Dental Health cover? **YES** / **NO** Are you happy for us to disclose information to your health fund? **YES** / **NO**

Who is your medical doctor?_____

Doctor's telephone number _____ or Suburb _____

Are you being treated by your doctor at present? **YES** / **NO**

Have you suffered or currently suffer from any of the following:

☐ Rheumatic fever ☐ Diabetes ☐ Epilepsy ☐ Heart ailments _____

☐ Kidney disease ☐ Asthma ☐ Hepatitis (any type) ☐ Blood pressure problems (especially high)

☐ Thyroid problems ☐ Pains in the chest ☐ Breathlessness ☐ Any contagious disease _____

Do you have any arthritis or any joint troubles, especially jaw? **YES** / **NO**

Do you suffer from clicking in the jaw or severe headaches? **YES** / **NO**

Are you taking any medicines or tablets? **YES** / **NO** Please list all medication _____

Have you ever had any allergies or adverse reactions to any pills, tablets or medicines? **YES** / **NO**

If so please list all _____

Any deep ray therapy to the head or neck? **YES** / **NO** An unfavourable reaction from local or general anaesthetics? **YES** / **NO**

Excessive bleeding following injury or dental procedures? **YES** / **NO** Any previously difficult extractions? **YES** / **NO**

Have you seen a specialist for dental treatment (e.g. Periodontist)? **YES** / **NO**

When was the last time you had a dental or survey x-rays taken? (please specify) _____

Do you smoke? **YES** / **NO** If yes, how many a day? _____

Are you pregnant? **YES** / **NO** Is there anything you wish to discuss with the dentist? _____

Patient's/Parent's signature _____ **Dentist's signature** _____

Today's date _____ **Today's date** _____