

# KALAMUNDA DENTAL CARE

## New Patient Pre-Treatment Details

**Welcome to our Practice! Please answer the following questions as accurately as possible to assist us in our effort to provide the best possible dental care for you. All information provided will be treated with complete professional confidentiality.**

*(Please circle answer where required)*

Title: Dr \_\_\_\_\_ Mr. \_\_\_\_\_ Mrs \_\_\_\_\_ Ms \_\_\_\_\_ Miss \_\_\_\_\_  
Surname: \_\_\_\_\_ First Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_  
Address: \_\_\_\_\_ Postcode: \_\_\_\_\_  
Telephone: (Hm) \_\_\_\_\_ (Wk) \_\_\_\_\_ (Mob) \_\_\_\_\_  
Email: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Work Address \_\_\_\_\_

Person responsible for the payment of your account? \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Preferred payment method: Cash \_\_\_\_\_ EFTPOS \_\_\_\_\_ Credit Card \_\_\_\_\_

Are you with a private health fund? Yes No Which fund? \_\_\_\_\_ How long been member? \_\_\_\_\_

Who can we thank for your referral to our practice? \_\_\_\_\_

### DENTAL HISTORY

Do you have an immediate dental problem? Please describe: \_\_\_\_\_

How long has it been since your last dental examination? \_\_\_\_\_ Were x-rays taken? Yes No

Are any of your teeth sensitive to: (please circle) Hot \_\_\_\_\_ Cold \_\_\_\_\_ Sweets \_\_\_\_\_ Chewing \_\_\_\_\_

Have you noticed any bad taste or odour from your mouth? Yes No

Do you suffer from sores, ulcers or blisters in your mouth? Yes No

Have you noticed any loose teeth in your mouth? Yes No

Does food tend to get caught in your teeth? Yes No

How often do you brush your teeth? \_\_\_\_\_ How often do you use dental floss? \_\_\_\_\_ Do your gums bleed or hurt? Yes No

*Do you ever:*

Clench or grind your teeth? Yes No Bite your lips or cheeks? Yes No

Breathe through your mouth? Yes No Smoke Tobacco? Yes No

Hold foreign objects in your teeth? Yes No Do you want to quit? Yes No  
(pens, pins, nails etc)

*Have you ever had:*

Braces or orthodontic treatment? Yes No A bite plate? Yes No

Wisdom tooth removal? Yes No A custom fit mouth guard? Yes No

Any serious injury to the mouth or head? Yes No Root Canal Treatment? Yes No

*Have you ever experienced:*

A stiff jaw on waking? Yes No Clicking or locking jaw? Yes No

Difficulty in chewing on either side of the mouth? Yes No Headaches? Yes No

Difficulty in opening or closing the mouth? Yes No Any jaw or facial pain? Yes No

Sore muscles of the jaw, neck or shoulders? Yes No

Are you conscious of the colour or appearance of your teeth? Yes No \_\_\_\_\_

Would you like to keep all your teeth for life? Yes No \_\_\_\_\_

How would you rate your general dental health? 1 2 3 4 5 6 7 8 9 10 (excellent)

How nervous are you about having dental treatment? 1 2 3 4 5 6 7 8 9 10 (very nervous)

Have you ever had an upsetting dental experience? Yes No \_\_\_\_\_

What are your biggest concerns about dental treatment? \_\_\_\_\_

Please describe anything else about having dental treatment that you would like us to know? \_\_\_\_\_

**CONFIDENTIAL MEDICAL HISTORY**

1. Have you been under the care of a medical doctor during the past **two** years? Yes No  
 If Yes, for what condition? \_\_\_\_\_  
 Doctor's Name: \_\_\_\_\_ Phone \_\_\_\_\_  
 Address: \_\_\_\_\_ Postcode \_\_\_\_\_
2. Have you taken any medications or drugs during the past **two** years? Yes No
3. Are you taking any prescription or over-the-counter medications or drugs? Yes No  
 If yes, please list name and dosages: \_\_\_\_\_  
 \_\_\_\_\_
4. Are you aware of having an allergic or adverse reaction to any medication or substance? Yes No  
 If Yes, please list: \_\_\_\_\_
5. Have you had any surgery or been admitted into hospital during the past **five** years? Yes No

6. Please indicate which of the following you have a history of or have at present *(Please Circle Yes or No and provide further details below)*

Heart Issues (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No
Chest pain	Yes	No	Diabetes	Yes	No
Congenital Heart Disease	Yes	No	Thyroid problems	Yes	No
Heart Murmur	Yes	No	Kidney problems	Yes	No
High or Low Blood Pressure	Yes	No	Emphysema	Yes	No
Mitral Valve Prolapse	Yes	No	Lung Disease	Yes	No
Artificial Heart Valve	Yes	No	Asthma	Yes	No
Heart Pacemaker	Yes	No	Chronic cough	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No
Cortisone treatment	Yes	No	Hay Fever	Yes	No
Arthritis	Yes	No	Sinus Problems	Yes	No
Osteoporosis	Yes	No	Latex Allergy	Yes	No
Artificial Joints (Hip, Knee etc)	Yes	No	Radiation Therapy	Yes	No
Transplanted organ or bone marrow	Yes	No	Chemotherapy	Yes	No
Diet Changes (special/restricted)	Yes	No	Tumors	Yes	No
Neurological Disorders	Yes	No	Cold sores	Yes	No
Epilepsy or Seizures	Yes	No	Blood transfusion	Yes	No
Stroke	Yes	No	Blood Disorders	Yes	No
Fainting or Dizzy spells	Yes	No	Bruise or Bleed Easily	Yes	No
Mental Illness	Yes	No	Multiple Sclerosis	Yes	No
AIDS	Yes	No	Liver Disease	Yes	No
HIV Positive	Yes	No	Hepatitis A B C	Yes	No

7. Have you had any significantly large weight loss or gain in the past year? Yes No
8. Do you have or have a history of any disease, condition or problem not listed? Yes No  
 If Yes, please list: \_\_\_\_\_
9. **Females Only:**
- Are you: Pregnant? Yes No How many months? \_\_\_\_\_  
 Breastfeeding? Yes No  
 Taking birth control pills? Yes No

**CONSENT FOR DENTAL TREATMENT (over 16 years of age)**

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist of any changes to my health or medication status.*

*I hereby authorize the dentist and designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs and upon diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ any assistance as required to provide proper dental care.*

*I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.*

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_