Welcome to No Gaps Dental

In order to provide you with safe and efficient dental care, it is necessary to collect the following information from you. We respect your privacy and information provided will be kept confidential in accordance to the Privacy Act 2000.

PERSONAL DETAILS

Title: ❑ Dr ❑ Mr ❑ Mrs ❑ Ms ❑ Master ❑ Miss		
Surname:	First Name:	DOB:
Address:	Suburb:	Postcode:
Home No.:	Mobile No.:	
Occupation:	Work No.:	
E-mail address:		
Do you have a Private Health Fund? ❑ Yes ❑ No	If yes, Name of the fund:	
Membership No.:	ID# on card (1, 2, 3 etc):	Date joined:
Medicare No.:	ID# on card (1, 2, 3 etc):	

How did you find out about No Gaps Dental?

Google	❑	Letter Box Drop	❑	Local Newspapers	❑	Radio	❑
Website	❑	Signage	❑	Yellow Pages	❑	Yellow Pages Online	❑
Family / Friends	❑	Health Fund	❑	Other (please specify):			

EMERGENCY CONTACT

Person to contact in the case of emergency:	
Relationship to patient:	
Contact No.:	Mobile No.:

GENERAL PRACTITIONERS DETAILS

Your GP's Name:
Address:
Contact No.:

DENTAL HISTORY

When was the last time you visited the dentist?	❑ 6mths	❑ 1yr	❑ 18mths	❑ 5yrs	❑more than 10yrs
Do you have prolonged/excess bleeding after an extraction?		❑ Yes	❑ No		
How often (daily) do you brush your teeth?	❑ once	❑ twice	❑ 3 times	❑ do not brush	
How often (daily) do you floss your teeth?	❑ once	❑ twice	❑ 3 times	❑ do not floss	

What problems do you experience?

Bleeding gums	❑	Painful/sore gums	❑	Swollen gums	❑	Sharp teeth	❑
Bad breath	❑	Sensitivity to hot/cold	❑	Grinding your teeth	❑	Clenching your jaw	❑
Tooth discolouration	❑	Other (Please specify):					

If you have ever had a bad dental experience, what was it?

What other way/s are you dissatisfied with your teeth?

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MEDICAL HISTORY

Do you suffer or have you ever had any of the following medical conditions or treatments:

	Present	Past	Never		Present	Past	Never
Anaemia	❑	❑	❑	HIV / AIDS	❑	❑	❑
Arthritis	❑	❑	❑	Kidney disease	❑	❑	❑
Artificial Joints	❑	❑	❑	Liver Disease	❑	❑	❑
Artificial Heart Valve	❑	❑	❑	Lung disease	❑	❑	❑
Asthma / Hay fever	❑	❑	❑	Osteoporosis	❑	❑	❑
Blood transfusion	❑	❑	❑	Panic Attacks	❑	❑	❑
Diabetes	❑	❑	❑	Radiation Therapy	❑	❑	❑
Epilepsy	❑	❑	❑	Rheumatic fever	❑	❑	❑
Fainting attacks	❑	❑	❑	Steroid Therapy	❑	❑	❑
Heart disease	❑	❑	❑	Stomach conditions	❑	❑	❑
Hepatitis B	❑	❑	❑	Stroke	❑	❑	❑
Hepatitis C	❑	❑	❑	Thyroid disease	❑	❑	❑
High / Low blood pressure	❑	❑	❑	Tuberculosis	❑	❑	❑

Other conditions (please provide details):

Are you allergic to any of the following:

	Yes	No		Yes	No
Aspirin	❑	❑	Iodine	❑	❑
Codine	❑	❑	Latex	❑	❑
EES Medicine	❑	❑	Panadol	❑	❑
Epilim	❑	❑	Penicillin	❑	❑

Other allergies (please provide details):

If female, are you pregnant? ❑ Yes _____ months ❑ No

Are you taking Fosamax? ❑ Yes ❑ No

Are you taking/or have you even taken anticoagulants (aspirin)? ❑ Yes ❑ No

What medication are you currently taking?

What medical treatment you are currently under?

Do you smoke? ❑Yes ❑No

I have answered all the questions to the best of my knowledge and understand that I need to inform the surgery about any changes to my medical health and personal details. If further information is required, I give my permission for the surgery to contact my general practitioner.

I agree to assume all financial responsibility for all treatment rendered, and understand that full payment is required on the day of treatment. I agree to cover all costs incurred to recover any outstanding debt for which I am responsible, including debt collectors and legal fees. (Any patient under 18 must have a consenting adult sign this form)

Signature: _____ **Date:** _____

Thank you for taking the time to complete this form