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. Detailed information about your privacy can found at the back of your clipboard.

PERSONAL DETAILS

Title: ❑ Dr ❑ Mr ❑ Mrs ❑ Ms ❑ Master ❑ Miss | Gender: ❑ Male ❑ Female ❑ Other

Surname: | First Name: | Date Of Birth:

Address: | Suburb: | Postcode:

Home No.: | Mobile No.:

Are you an intersate or overseas visitor to Sydney ❑ Yes ❑ No | Is English your first language? ❑ Yes ❑ No

Occupation: | Work No.:

What is your highest level of education?

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):

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	❑	2Day FM	❑
Family / Friends	❑	Health Fund	❑	Yellow Pages Online	❑	Nova 969	❑
						AM	❑
Other (please specify):						Other / Unsure	❑

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?

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 Approx due date _____ ❑ No

Are you taking any bisphosphonates (ie. Fosamax, Prolia, etc)? ❑ Yes ❑ No

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

What medication are you currently taking?

What medical treatment you are currently under?

Do you smoke? ❑Yes ❑No

Do you use recreational drugs/controlled drugs ❑Yes ❑No

❑ ***I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist about this***

I have answered all the questions to the best of my knowledge and understand that I it is my responsibility 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 have read and accept the privacy policy. I understand and accept that a cancellation fee will apply if I do not provide a minimum of 24hours notice of not being able to attend my appointment. I agree to assume complete financial responsibility for my account and understand that **full payment is required on or before the day of treatment**. I understand and agree that in the event of my account remaining unpaid and being referred to a debt collection agency and/or law firm, all collection and legal demand costs will be added to my account for which I am responsible for.

Signature: _____ **Date:** _____

Any patient under the age of 18yrs old must have a consenting adult sign this form

Thank you for taking the time to complete this form