**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. Our Privacy Policy can be found at the back of your clipboard and on our website.

## PERSONAL DETAILS

| | | |
|---|---|---|
| Title: ❑ Dr ❑ Mr ❑ Mrs ❑ Ms ❑ Master ❑ Miss | | Gender: ❑ Male ❑ Female ❑ Other |
| Surname: | First Name: | Date Of Birth: |
| Address: | Suburb: | Postcode: |
| Contact No.: | Is English your first language? ❑ Yes ❑ 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.): | |
| Medicare No.: | ID# on card (1, 2, 3 etc.): | |

How did you find out about No Gaps Dental?

| | | | | |
|---|---|---|---|---|
| Google ❑ | Website ❑ | Social Media ❑ | Health Fund ❑ | Signage ❑ |
| Family / Friends ❑ | Radio: KIIS 106.5 ❑ | Smooth FM 95.3 ❑ | Other / Unsure ❑ | |

Other (please specify):

## EMERGENCY CONTACT

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

## GENERAL PRACTICIONER DETAILS

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

## DENTAL HISTORY

| | | | |
|---|---|---|---|
| When was the last time you visited the dentist? | ❑ 6mths | ❑ 1yr | ❑ more than 2yrs |
| How often (daily) do you brush your teeth? | ❑ once | ❑ twice | ❑ do not brush |
| How often (daily) do you use interdental product e.g. floss, piksters? | ❑ once | ❑ twice | ❑ do not use |

What dental problems do you experience?

| | | | |
|---|---|---|---|
| Bleeding gums ❑ | Painful/sore gums ❑ | Food trapped between teeth ❑ | Sharp teeth ❑ |
| Bad breath ❑ | Sensitivity to hot/cold ❑ | Grinding/clenching ❑ | Mouth breathing ❑ |

Other (Please specify):

Are you concerned with (Please tick all that apply)?

| | | | |
|---|---|---|---|
| Existing crown/bridge or denture ❑ | Crooked teeth ❑ | Silver filling ❑ | Gaps between teeth ❑ |
| Previous dental treatment ❑ | Missing teeth ❑ | Tooth discolouration ❑ | Worn/broken teeth ❑ |

Do you play contact sport? ❑ Yes ❑ No

If Yes, do you have a custom-made mouthguard? ❑ Yes ❑ No

Do you wear a splint/night guard? ❑ Yes ❑ No

## MEDICAL HISTORY

Do you suffer or have you EVER had any of the following medical conditions or treatments?

| *Medical condition* | *Yes* | *No* | *Medical condition* | *Yes* | *No* | *Medical condition* | *Yes* | *No* |
|---|---|---|---|---|---|---|---|---|
| Anaemia | ❑ | ❑ | Gastric Reflux | ❑ | ❑ | Lung Disease | ❑ | ❑ |
| Arthritis / Rheumatism | ❑ | ❑ | Head / Neck Injury | ❑ | ❑ | Osteoporosis | ❑ | ❑ |
| Artificial Heart Valve | ❑ | ❑ | Heart Disease | ❑ | ❑ | Pacemaker | ❑ | ❑ |
| Artificial Joints (Eg. Hip, Knee) | ❑ | ❑ | Hepatitis A, B Or C | ❑ | ❑ | Panic Attacks | ❑ | ❑ |
| Asthma / Hay Fever | ❑ | ❑ | High Blood Pressure | ❑ | ❑ | Radiation / Chemo Therapy | ❑ | ❑ |
| Blood Transfusion | ❑ | ❑ | HIV / AIDS | ❑ | ❑ | Rheumatic Fever | ❑ | ❑ |
| Depression / Anxiety | ❑ | ❑ | Kidney Disease | ❑ | ❑ | Steroid Therapy | ❑ | ❑ |
| Diabetes | ❑ | ❑ | Liver Disease | ❑ | ❑ | Stroke | ❑ | ❑ |
| Epilepsy | ❑ | ❑ | Low Blood Pressure | ❑ | ❑ | Thyroid Disease | ❑ | ❑ |
| Fainting attacks | ❑ | ❑ | | | | | | |

Other conditions (please provide details):

Do you have any **allergies or abnormal reactions** to drugs, food, anaesthetics or materials? (Please provide details):

If female, are you pregnant? ❑ Yes ❑ No If Yes, when are you due (month + year) _____

Have you ever taken any bisphosphonates medications (i.e. Fosamax, etc)? ❑ Yes ❑ No

Are you currently taking any blood thinners (i.e. Aspirin)? ❑ Yes ❑ No

What medication/s are you currently taking? (Including over the counter and herbal/natural products) Please list:

Are you currently under any medical treatment? ❑ Yes ❑ No

Have you been hospitalised in the past 6 months? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No If Yes, how many do you smoke per day? _____

Clinician's note:

I have answered all the questions to the best of my knowledge and understand that 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.

For any patient under the age of 18yrs old, a parent / guardian is required to sign this form, and provide the following details:

Name of parent / guardian: _____

Residential address: _____

Contact Number: _____

**Signature:** _____ **Date:** _____

**Thank you for taking the time to complete this form**