Bayside

FAMILY DENTISTRY

WELCOME TO OUR SURGERY

Please fill in the following form with your medical and dental history.

Title:	
Surname:	
Name:	
Date of birth:	
Home address:	
Home phone number:	
Work phone number:	
Mobile phone number:	
Email:	
First language:	
Occupation:	
Work address:	
Next of kin:	
Phone number of next of kin:	
Doctor:	

Do you have private health insurance? YES / NO

If so, which fund? _____ Membership Number: _____

Reference:

_____

Do you have an existing illness? YES / NO

If yes, please describe:

_____

_____

_____

Have you been hospitalised within the past two years ? YES / NO

If so, for what reason ?

_____

Are you a smoker? YES / NO
If yes, how many do you smoke per day? _____

Do you have problems with a dry mouth? DAY TIME / NIGHT TIME / BOTH / NONE

Do you bleed excessively when you cut yourself ? YES / NO

Are you currently taking any medication? YES/NO
If so, please list:

_____

_____

_____

If female, are you pregnant or possibly pregnant? YES / NO
If so, how many weeks are you? _____

Are you allergic to any of the following:

☐ Penicillin ☐ Local anaesthetics ☐ Other antibiotics ☐ Latex ☐ None

PLEASE TICK IF ANY OF THE FOLLOWING APPLY TO YOU:

☐ Heart Disease	☐ High blood pressure	☐ Stomach Ulcers
☐ Heart surgery	☐ Low blood pressure	☐ Heart Murmur
☐ Blood disease	☐ Kidney disease	☐ Rheumatic Fever
☐ Diabetes	☐ Liver disease	☐ Epilepsy
☐ Stroke	☐ Lung disease	☐ Hay fever/Sinus
☐ Asthma	☐ Thyroid problems	☐ Headaches
☐ Joint replacement	☐ Tumour history	☐ Back and/or neck pain
☐ Hepatitis A B or C	☐ Radiation treatment	☐ Ear, nose, throat problems
☐ AIDS	☐ Osteoporosis	☐ Sleep Apnea

PLEASE TICK IF ANY OF THE FOLLOWING APPLY TO YOU:

☐ Painful tooth or gums	☐ Swollen/bleeding gums	☐ Mouth breathing
☐ Mouth Ulcers	☐ Tooth grinding	☐ Tooth crowding
☐ Jaw clenching	☐ Tongue/cheek irritation	☐ Jaw pain
☐ Poor bite	☐ Jaw joint click or pain	☐ Snoring
☐ Speech problems		

Are you happy with your smile? YES/NO

How do you rate your smile on a scale 1 – 10 ?

_____

(1= Not happy at all or 10 = Very happy and don't require any changes)

How would you improve it?

_____

_____

What are your main concerns? ☐ Tooth shape ☐ Tooth position ☐ Tooth colour

Do you have any habits? ☐ Thumb sucker ☐ Nail biter ☐ Pen chewer

How long since your last visit? _____

What is the main concern for your visit today?

_____

_____

How did you find our surgery?
Please tick one of the boxes below:

☐ Passing premises ☐ Google ☐ New Neighbours Letter

☐ Website ☐ Health Engine ☐ Neighbourhood Watch Newsletter

☐ Facebook ☐ Instagram ☐ HCF Members

☐ Recommendation ☐ Kinder Dental Presentation ☐ Bayside Community Hub

If so, who?

_____

Signature of the person responsible for account: Date:

_____ _____