HEDLAND
DENTAL CARE

19 Edgar Street, PORT HEDLAND WA FREECALL **1800 230 230**

We ask you to provide the following pre-treatment information. The information we collect enables us to care for you better. We value your privacy, so all details will be kept strictly confidential.

YOUR DETAILS

Title Mr Mrs Ms Miss Dr (other.....)

Surname.....

Given Name(s).....Date of Birth.....

Postal Address.....

.....Post Code.....

Home Phone ..... Work Phone.....

Mobile Phone ..... Employer.....

Occupation ..... HEALTH FUND: .....

Email ..... MEMBER No:.....SERIES:.....

Next of Kin: ..... Relationship to patient: .....

Next of Kin Phone No: .....

HEALTH INFORMATION

Please tick as appropriate.	**Yes**	**No**
Have you had any significant medical problems in the last year?	☐	☐
Do you take any prescribed drugs, tablets, medicines or creams?	☐	☐

Please Specify:

.....

Have you had any adverse reactions to any treatments or medications?	**Yes**	**No**

Please Specify:

.....

Do you currently, or have you ever suffered from any of the following conditions?

Please tick as appropriate.	**Yes**	**No**		**Yes**	**No**
HIV,or AIDS	☐	☐	Rheumatic Fever	☐	☐
Heart Disease	☐	☐	Liver disease	☐	☐
Blood Disorder/Disease	☐	☐	Hepatitis	☐	☐
High Blood Pressure	☐	☐	Kidney Disease	☐	☐
Low Blood Pressure	☐	☐	Epilepsy	☐	☐
Asthma	☐	☐	Diabetes	☐	☐
Heart Murmur	☐	☐			

If yes, please describe what type of heart murmur.....

Have you ever been told by a Medical Doctor that you need antibiotic cover prior to dental treatment?	**Yes**	**No**

Do you wish to discuss any medical conditions with your dentist privately	**Yes**	**No**
Do you have any prosthetic body parts? (Heart valves, hips etc....)	**Yes**	**No**

Please Specify.....

Are you taking steroid medications? (eg. Cortisone)	☐	☐

Please Specify.....

Are you taking anti-depressant medication? **Yes** **No**

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Please tick as appropriate.	**Yes**	**No**	
Are you pregnant?	☐	☐	How many weeks?.....
Do you have any **allergies?**	☐	☐	Please specify.....

How many cigarettes do you smoke each day .....

How would you rate your overall general health? PERFECT/ GOOD/ FAIR/ POOR/

DENTAL INFORMATION

What are you expecting from your visit today?

.....

Future:.....

How do you rate the overall condition of your mouth – on a scale of 1 (poor) to 5 (excellent)

1.....2.....3.....4.....5.....

Do you have any of the following problems? Tick all that apply.

Toothache	☐	Crooked/Crowded teeth	☐
Discoloured teeth	☐	Bleeding gums	☐
Loose teeth	☐	Missing teeth	☐
Unsatisfactory denture	☐	Pain in face/jaw	☐
Lost filling/cavity	☐	Sensitive	☐

Are you happy with the appearance of your teeth **Yes No**

If NO – Why.....

Would you like information on tooth whitening **Yes No** When did you last see a Dentist?.....

What was the treatment performed? .....

Why did you leave your last Dentist?.....

Who referred you to our practice?

Yellow Pages ☐ Tourist Magazine ☐

Another Patient ☐ (What is their Name?).....

Staff Member ☐ (What is their Name?).....

How can we make your dental visit with us more comfortable?

.....

I understand that payment is required on completion of treatment

My preferred method of payment is:

Cash ☐ EFTPOS ☐ MasterCard ☐ Visa ☐

Signature:..... Date:.....

Please sign and return to front office Coordinators

Signature:..... Date:.....

Signature:..... Date:.....

Signature:..... Date:.....