MORPHETT ST
Family Dental

PATIENT DETAILS

Title: Surname: First Name:

Preferred Name: Date of Birth:

Home Address: P/Code:

Postal Address: P/Code:

H: Mobile: (BH) PH:

Preferred phone: ☐ Home ☐ Mobile ☐ Work

Email:

Name of person responsible for account: Relationship:

Would you like information regarding payment plans? ☐ Yes ☐ No

Emergency contact: Relationship:

Address:

PH:

Medical Doctor:

Address:

Do you give us consent to contact your doctor for further information if required? ☐ Yes ☐ No

Do you have Private Health Insurance: ☐ Yes ☐ No DVA ☐ Yes ☐ No

If YES, which health fund?

How did you find us? ☐ Advertisement ☐ Facebook ☐ Google

☐ Recommended by_____ ☐ Other: _____

DENTAL HISTORY

Reason for today's visit:

How long has it been since your last dental examination?

Do you have any of the following dental concerns?

☐ Toothache	☐ Bleeding gums	☐ Dry mouth
☐ Missing Teeth	☐ Difficulty chewing	☐ Lost filling or cavity
☐ Pain in face or jaw	☐ Discoloured teeth	☐ Grinding/clenching
☐ Sensitive Teeth	☐ Unhappy with appearance	☐ Loose Teeth
☐ Poor fitting denture	☐ Bad breath	☐ Worn or broken teeth

Please complete both sides

MEDICAL DETAILS

Have you ever had any of the following? Please tick:

	YES	NO		YES	NO
High Blood Pressure			Kidney Disease		
Heart Ailment / Stroke			Thyroid Problems		
Rheumatic Fever			Excessive Bleeding / Blood Disorders		
Asthma, Chest or Breathing Problems			Bone Disorders (e.g. osteoporosis)		
Tuberculosis			Hepatitis		
Diabetes			AIDS/HIV		
Depression / Anxiety			Cancer		
Stomach or Bowel Problems			Epilepsy		
Do you smoke? ☐ Previously ☐ Yes ☐ No How many? /day			Female Patients, are you pregnant?		
List any previous illnesses:					
Have you ever had any problems with dental treatment?					
Do you have: an artificial hip, heart valve or prosthetic implant?					
Do you have any allergies, such as latex? (If yes, please list)					
Are you presently under medical care?					
Are you taking any drugs, medicines or tablets, including natural remedies? (If yes, please list)					

Would you like to receive email updates from our practice? ☐ *Yes* ☐ *No*

Are you happy to receive reminders by: ☐ *Phone* ☐ *SMS* ☐ *Email*

I have completed this questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place me at undue risk. I give permission for Morphett St Family Dental to use the above contact details to send me appointment and check up reminders. I understand that payment of accounts is required on the day unless otherwise pre arranged.

Your information is maintained in accordance with State and Federal Privacy Legislation If you would like to view our Privacy Policy, please ask one of our staff members.

Patient Signature: _____ *Date:* _____

Please complete both sides