Dental at Atune
52 Ada Street
CARDIFF NSW 2800
Ph: 4089 2800
Website: www.dentalatatune.com.au

Welcome to our Practice! Please answer these questions as completely as possible. It will assist us greatly in our effort to provide the best dental treatment for you.

Full Name: Mr / Mast / Mrs / Miss / Ms

Address: _____

Suburb: _____ Postcode: _____

Mobile: _____ Ph Work _____ Ph Home _____

Date of birth_____ Occupation _____

Email address _____

Person responsible for fees _____

Emergency contact – Name _____ Contact No _____

What dental insurance or benefit do you have? _____

MEDICAL HISTORY

Who is your medical doctor? _____ Ph No _____

Have you had any serious health problems during the past year?

_____

_____

Do you take prescribed medication regularly? _____ If yes, please list names of all medications.

_____

Do you take blood thinning medication eg.. warfarin, aspirin _____

Have you ever had excessive bleeding whilst in the dental chair? _____

Are you allergic to Penicillin or any other medication or Foods? _____

Do You Or Have You Ever Suffered From Any Of The Following? (Please circle)

□ Heart/Vascular Disorder	□ Asthma □ Reflux	□ Diabetes 1 or 2
□ High /Low Blood Pressure	□ Breathing difficulties	= Epilepsy, seizures
□ Rheumatic Fever	□ Hepatitis A B C	□ mouth Ulcers lumps, spots of concerns
□ Glandular fever	□ HIV/AIDS	□ Latex Allergy /milk allergy
□ Joint Replacement	□ Cancer	= please list other ailments below
□ Liver /Kidney or lung Disease	□Pacemaker/ Defibrillator	

Please turn over

Do you smoke? _____ If so, how many per day? _____

(Women) Are you pregnant? _____ How many months? _____

DENTAL HISTORY

Are you concerned about or experiencing any of the following dental problems? (Please tick)

□ Sensitivity to hot or cold	□ Food trapping between teeth	□ Clicking/pain in the jaw joints
□ Staining of your teeth	□ Discoloured fillings	□ Roughness of existing fillings
□ Bleeding gums	□ Bad breath	□ Sensitivity when eating
□ Head/neck ache	□ Grinding/clenching of your teeth	□ Numbness
□Lumps or sores	□ Existing crowns/bridges /Dentures	□ List other concern

What treatment do you require today? _____

_____

How long since your last dental visit? _____

Does dental treatment make you nervous? □ No □ Slightly □ Moderately □Extremely

Who referred you to our Practice? _____

CONSENT FOR SERVICES

- I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated and I will assume responsibility for the fees associated with those procedures.
- I understand that the practice requires at least **24 hours notice** if I need to cancel my scheduled appointment and **MUST** be **CONFIRMED 48 HRS prior** to your appointment.
- Many emergencies are turned away in the expectation that you will arrive, if this case arises we may elect to give your appointment to others in pain/ or emergency situations, please understand
- I hereby authorise the dentist/hygienist to take x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis.
- I am aware that **payment is required** on the **day** of treatment.

Patient/Parent/Carer Signature _____ Date _____

OFFICE USE ONLY

Updated: _____ Signature: _____ Scanned: _____