Stirling Street
DENTAL CLINIC

(Mr/Mrs/Ms/Miss) First name: _____Surname:_____
Address: _____
_____ Suburb: _____ Post Code _____
Phone (Home)_____Mobile: _____ Work: _____
Date of Birth: _____/_____/_____Occupation: _____
Name of Private Health Fund: _____ Membership No. _____
Whom may we thank for your referral? _____

Medical History

Please ☑ if you have/had the following conditions

Asthma	☐	**High or low blood pressure**	☐
Blood disorder	☐	**HIV or AIDS**	☐
Blood thinning medication	☐	**Joint replacement**	☐
Diabetes	☐	**Osteoporosis**	☐
Epilepsy	☐	**Radiation therapy**	☐
Heart surgery or complaint	☐	**Rheumatic fever**	☐
Hepatitis	☐	**For females: are you pregnant**	☐
Do you smoke	☐		

Allergy to any medication (eg. Penicillin, codeine)/ Food or substances (eg. Latex, Iodine).
Please list _____
If you are on medication, please list:_____
_____

Name of Family Doctor: _____ Phone number: _____

REASONS FOR THIS DENTAL VISIT: Please ☑

Dental check up	☐	**Teeth whitening**	☐
Scale and polish	☐	**Invisalign (clear braces)**	☐
Broken tooth or filling	☐	**Dental implants**	☐
Decay/hole in tooth	☐	**Bleeding gums**	☐
Wisdom teeth problem	☐	**Teeth Grinding or clenching**	☐
Toothache	☐	**Denture**	☐
Crowns/Veneers/Bridges	☐	**Sleep Apnea, snoring or other sleep problems**	☐
Treatment under IV sedation (asleep) or nitrous (laughing gas)			☐

Others _____

I ACKNOWLEDGE THE INFORMATION GIVEN ABOVE IS ACCURATE
I UNDERSTAND PAYMENT IS REQUIRED AT THE END OF EACH VISIT
I AGREE TO ACCEPT ANY COST INCURRED FOR THE RECOVERIES OF AN OUTSTANDING ACCOUNT

SIGNATURE: _____ DATE: _____