ProSmile DENTAL CARE

Welcome

To help us provide you with the best dental care, please take the time to complete this form.
All information will remain confidential.
We look forward to a long and healthy dental relationship.

Title:_____First Name:_____ Lastname:_____Date of Birth:___ /___ /___
Address:_____ Suburb:_____ Post Code:_____
Phone # H:_____ W:_____ M:_____
Email:_____ Occupation:_____
Are you with any Australian Health Fund? Y / N If yes, **Name of Health Fund**:_____
How did you hear about ProSmile Dental Care*?:*_ _____

Medical History

Have you been a patient in hospital in the past 5 years? Y / N_____
Have you ever had a serious illness? Y / N_____
Are you taking any medication? Y / N_____ Are you allergic to any medication, including Penicillin? Y / N_____

Please indicate with of the following you have (or had); and provide details:

Heart (disease, surgery, attack) ☐	**Allergies** ☐	**Diabetes** ☐	**Rheumatic fever** ☐
High/low blood pressure ☐	**HIV/AIDS** ☐	**Glaucoma** ☐	**Thyroid disease** ☐
Blood transfusion ☐	**Asthma** ☐	**Hepatitis** ☐	**Hyperthyroidisms** ☐
Prolonged bleeding ☐	**Arthritis** ☐	**Smoking** ☐	**Neurological disorders** ☐

Ladies, are you:

Taking a birth control pill ☐	**Planning pregnancy** ☐	**Pregnant** ☐ **____months**	**Breastfeeding** ☐

Please provide more information if you have ticked 'YES' to any of the above or if you have or had any disease condition or problem not listed:

Dental History

What is the reason for your visit?_____
When did you last visit a dentist?_____ Dentist:_____ Address:_____
How often do you have dental examination?_____
How often do you brush your teeth?_____How often do you floss?_____
Do you have any dental problems now? Y/N_____
Is there anything else you wish to discuss with our dental team? Please feel free to write it down
_____

Signature:_____ Date:____ /____ /_____