WHITEHORSE
DENTAL

At Whitehorse Dental, we aim to provide you with the best possible care.
To help us achieve this please complete and sign these Patient Registration & Medical History Forms.

PRIVACY POLICY: We request the information set out below to provide you with effective and efficient dental services. You are entitled to access your information at any time and we will keep your information confidential. However, if necessary, we may forward your information to other health practitioners or debt collection agencies. We may also be required by law to provide your information to outside agencies. So please answer all questions. Also by signing this form you agree to give no later than 48 hours notice to cancel an appointment as fees can apply & to arrive to appointment at the scheduled time, as appointment may be forfeit due to late arrival.

PATIENT REGISTRATION FORM *Please Answer All Questions. It helps us help you!*

Title

Surname ______________________ **Given name** ______________________

Preferred name ______________________ **Date of birth** ______________________

Address & Suburb____ **P/Code**______

Home ________________ **Mobile** ________________ **Work** ________________

Email ____

Emergency contact ________________ **Relationship** ____________ **Ph** ____________

Medical Doctor ____ **Ph** ____________

If patient is under 18, please state Father/Mother/Guardian's name ______________________

Who is responsible for the account if not yourself? ______________________________

Do you have private health insurance for dental cover? Yes No Fund name____________

How did you hear about our dental practice?
Recommendation Google Walking Past Facebook was a previous client Other

If recommendation; by whom: ____

To help you relax in our surgery, we would like to play some of your favorite music. Please list some of your favorite artists / genre…

____

Photos and X rays of teeth taken may be used for teaching and discussion purposes with other dental professionals. Such material will be de-identified so that they are anonymous. Please advise us if you do not wish for this to occur.

I do not wish for my x rays or photos to be used for educational purposes

Signature____________________________________ Date ____________

MEDICAL HISTORY FORM

Have you had or do you currently have?

	YES	NO
Heart Conditions		
Artificial Joints (e.g. knee, hip)		
Tumors / Cancer		
Hepatitis		
HIV Positive		
Blood Disorders (anemia, etc)		
Blood Pressure High / Low		
Kidney / Liver Disease		
Ulcers: Stomach / Mouth		
Snoring / Sleep Apnea		
Diabetes		

If yes which type? Type I Type II

Ladies: Are You Pregnant? ____

	YES	NO
Tuberculosis		
Epilepsy		
Creutzfeldt-Jakob Disease		
Rheumatic fever		
Venereal Disease		
Asthma		
Sinus Issues [Not Allergies]		
Neurological Disorders		
Thyroid Disease		
Cold Sores		
Do you smoke?		

Cigarettes a day ____ For ____ Years

Taking Birth Control Pills? ____

If you have answered yes to any of the above questions, or have a condition that's not listed, please provide more details below:

____

____

____

____

Please list the name, purpose and dosage of any medications that have been taken in the last 2 years:

____

____

____

Have you or are you taking any Bisphosphonates or injections for your bones?
e.g Didronel, Bonefos, Fosamax, Alendro, Actonel, Skelid, Aredia Zometa YES NO

Do you have any Allergies: YES NO
If Yes, please list: Penicillin Codeine Latex

Other______________________________

____

Are you aware of having any allergic or adverse reaction to any medications or substances?
YES NO

If Yes please list

____

____

Signature______________________________ Date ______________

DENTAL HISTORY

How would you rate the condition of your mouth? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Previous Dentist________________________How long have you been a patient?____________________Months/Years

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ______________________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	☐ ☐ ☐	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]		☐	☐
2. Have you had an unfavorable dental experience?		☐	☐
3. Have you ever had complications from past dental treatment?		☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?		☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?		☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?		☐	☐

GUM AND BONE	☐ ☐ ☐	YES	NO
7. Do your gums bleed or are they painful when brushing or flossing?		☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?		☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?		☐	☐
10. Is there anyone with a history of periodontal disease in your family?		☐	☐
11. Have you ever experienced gum recession?		☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?		☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?		☐	☐

TOOTH STRUCTURE	☐ ☐ ☐	YES	NO
14. Have you had any cavities within the past 3 years?		☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?		☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?		☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?		☐	☐
18. Do you have grooves or notches on your teeth near the gum line?		☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?		☐	☐
20. Do you frequently get food caught between any teeth?		☐	☐

BITE AND JAW JOINT	☐ ☐ ☐	YES	NO
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)		☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?		☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?		☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?		☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?		☐	☐
26. Are your teeth developing spaces or becoming more loose?		☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?		☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?		☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?		☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?		☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?		☐	☐
32. Do you wear or have you ever worn a bite appliance?		☐	☐

SMILE CHARACTERISTICS	☐ ☐ ☐	YES	NO
33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?		☐	☐
34. Are you considering whitening your teeth?		☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?		☐	☐
36. Have you been disappointed with the appearance of previous dental work?		☐	☐

Patient's Signature____Date ______________