Gladesville Gentle Dental

All information will be treated with complete confidentiality.

Surname:_____ First Name:_____
Mr / Mrs / Ms / Miss/ Others (please circle) Date of Birth:_____
Address:_____
Suburb: _____Postcode:_____
Ph (home):_____Ph (work):_____Mobile:_____
Email Address:_____
Occupation:_____
Referred by:_____
Do you have any dental insurance? NO/YES
(name):_____

Please circle the appropriate alternative only:

Do you take regular medications? NO/YES (please specify)_____
_____
Have you had any allergic reaction to any treatment or medication? NO/YES (please specify)

Have you ever had any of the following:

Heart/vascular disorder? NO/YES (specify)_____
Rheumatic fever/pacemaker/heart murmur? NO/YES (specify)_____
Osteoporosis? NO/YES (specify)_____
Bleeding disorder? NO/YES
(specify)_____
Blood pressure problem? NO/YES (specify)_____
Hepatitis/HIV? NO/YES (specify)_____
Asthma/other respiratory diseases? NO/YES
(specify)_____
Diabetes? NO/YES (specify)_____
Epilepsy? NO/YES
(specify)_____
Liver/Kidney diseases? NO/YES (specify)_____
Tuberculosis? NO/YES
(specify)_____
Depression? NO/YES (specify)_____
Hayfever/ sinus problems? NO/YES (specify)_____
Cancers/tumors? NO/YES (specify)_____
Any other diseases/operations? NO/YES (specify)_____
(For female patients only): Are you pregnant/breast feeding? NO/YES (due date)_____
Name of family doctor:_____

Dental Concerns:

Consent for Services

I have accurately completed this pre-clinical questionnaire to the best of my knowledge. I hereby give my authority for any treatment agreed upon by myself, to be carried out. I assume full financial responsibility for said treatment.

Patient Full Name: _____

Signature of patient/parent/guardian: _____**Date:** ___/___/____