Information Sheet

Whether you have visited the practice before or this is your first experience, the whole team would like to welcome you. In our constant effort to provide you with the very best service please provide the following information.

Where did you find Toothbrush Land's contact details? _____

Title_____Full Name_____DOB_____

Address_____

Phone H _____ W_____M _____ Email address _____

Occupation _____ Medicare card number _____Line No_____

Are you covered for Private Dental treatment Y/N if YES which fund? _____ Line Number _____

Smile Membership number _____ Expiry date _____ Dept. Veteran Affairs Gold card number _____

Are you interested in having Whiter teeth Y/N if yes Take Home or In-Chair Whitening Do you need a Sport Mouthguard? Y/N

Emergency contact details_____

Medical and Dental History – circle Yes (Y) or No (N) Below

Are you being treated by a medical doctor at present? Y/N Who is your current doctor? _____Contact No_____

Do you require antibiotic cover before dental treatment? Y/N Have you ever had any abnormal reactions to anaesthetics? Y/N

Have you been hospitalised in the last 2 years? Y/N Have you ever had difficult teeth extractions? Y/N

Do you smoke? Y/N If yes number per day_____ Are you pregnant? Y/N Female only

Are you taking any prescription drugs or other medication at present (including natural/herbal)? Please list below.

_____

Please list any allergies (including latex, food, preservatives) _____

When was your last DENTAL check-up? _____

Do you have now, or have you ever had any of the following MEDICAL CONDITIONS please circle Yes or No for each condition.

Heart Disease /high or low blood pressure	Y	N	Kidney disease	Y	N	Prosthetic implant eg. artificial hip	Y	N
Heart disorder complaint	Y	N	Bronchitis, emphysema or other lung condition	Y	N	Prolonged / excessive bleeding	Y	N
Rheumatic fever	Y	N	Tuberculosis- TB	Y	N	Cancer	Y	N
Stroke	Y	N	Bone disease including osteoporosis	Y	N	Radiation therapy	Y	N
Cardiac pacemaker	Y	N	Anaemia or other blood disorder	Y	N	Stomach or digestive conditions	Y	N
Diabetes	Y	N	Hepatitis, H.I.V, VRE or any other infectious disease	Y	N	Sleep apnoea	Y	N
Epilepsy	Y	N	Glaucoma	Y	N	Sinus problems	Y	N
Hyperthyroidism	Y	N	Nervous or psychiatric condition	Y	N	Dry mouth	Y	N
Steroid/cortisone therapy	Y	N	Asthma	Y	N	Other Conditions	Y	N

Any other conditions not mentioned please list

Payment for your dental treatment is on the appointment day THANK YOU

Your signature_____Date_____