

SECTION ONE: YOUR DETAILS

First Name(s)

Last Name:

Dr Mr Mrs Ms Miss Mstr

Date of Birth / /

How did you find out about McIntosh Dental?

Home Address:

Postcode _ _ _ _ _

Home phone:

Work Phone:

Mobile Phone:

Preferred contact method:

E-mail Address:

this address is: Home Work Other

Occupation:

Employer:

In case of an emergency, who can we contact?

Name:

Phone:

Relationship to you:

Are you under 18? Your School:

Parents Name:

SECTION TWO: YOUR DENTAL HISTORY

What is the reason for your visit today?

When was your last dental visit?

Who was your previous Dentist or Hygienist?

Are any of your teeth sensitive to:

Hot	YES	NO
Cold	YES	NO
Biting/chewing	YES	NO

What do you use to clean your teeth at home?

Have you ever had:

Orthodontics (braces)	YES	NO
Periodontal (gum) treatment	YES	NO
An injury to your teeth or jaws	YES	NO
Any dental infections/abscesses	YES	NO
Any teeth extracted	YES	NO
A bad dental experience	YES	NO

Do your gums bleed or hurt? YES NO

Have you ever been aware of:

Clicking or popping of the jaw	YES	NO
Jaw joint pain	YES	NO
Grinding/clenching	YES	NO
Head/neck/facial ache or pain	YES	NO

Would you like more information about:

Whitening your teeth	YES	NO
Straightening your teeth	YES	NO
Replacing missing teeth	YES	NO
Bad breath (Halitosis)	YES	NO
Any other dental treatment?		

SECTION THREE:**YOUR MEDICAL HISTORY**

1. Have you been under the care of a medical doctor? YES NO

If YES, what for?

Doctors Name:

Practice:

2. Are you currently taking any medications? YES NO

If YES, which medicines?

3. Are you aware of any allergies or adverse reactions that you have? YES NO

If YES, details:

4. Have you ever had, or been treated for any of these conditions?

Heart Trouble	YES	NO	Stroke	YES	NO
High Blood Pressure	YES	NO	Sinusitis	YES	NO
Blood Disorders	YES	NO	Allergies	YES	NO
Anaemia	YES	NO	Diabetes	YES	NO
Rheumatic Fever	YES	NO	Hepatitis	YES	NO
Asthma	YES	NO	Arthritis	YES	NO
Bronchitis	YES	NO	Epilepsy	YES	NO
Gastric Reflux	YES	NO	Fainting or Dizziness	YES	NO
Stomach Ulcer	YES	NO	Latex Sensitivity	YES	NO

5. Have you been treated for any other conditions not listed above? YES NO

If YES, please describe:

6. Do you believe yourself to be at risk from the HIV and/or Hepatitis virus? YES NO

7. Do you smoke? YES NO → if YES, amount per day:

8. Do you take any self-prescribed and/or recreational drugs? YES NO

If YES, details:

9. Women: Are you pregnant? YES NO → if YES, number of months:

SECTION FOUR:**OUR AGREEMENT**

OUR COMMITMENT TO YOU: At all times we will provide you the *very best dental care available* in a modern friendly environment. As a patient at McIntosh Dental, your well-being is our first priority.

YOUR COMMITMENT: I, the undersigned, agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. I understand that payment is due at the time of treatment unless other arrangements have been finalised and a 15% fee will be added to outstanding accounts. If required for debt collection, I understand that a check of my credit history may be made, and/or my details may be passed to a third party. I understand that by making appointments with McIntosh Dental Centre I am agreeing to attend the appointments or to give a minimum of 24 hours' notice of cancellation of appointments. If I fail to attend an appointment, a 'no-show' fee of \$50 per half hour of the appointment may be charged.

Signed _____ Date ___/___/20___ Checked _____