McIntosh Dental
Incorporating Lincoln Dental

Picture ☐
Entered ☐

To ensure that we can provide you with the very best care, please complete every question

SECTION ONE: YOUR DETAILS

First Names: Last Name:

Title: *(tick)* Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Master ☐ Other _____

Date of Birth: Gender:

Home Address:

Postcode:

Mobile Phone: Home phone:

Work Phone: Email:

Preferred contact method: *(tick)* Home ☐ Work ☐ Mobile ☐ Text ☐ Email ☐

How did you hear about McIntosh Dental? *(tick)*

Website ☐ **Facebook/Social Media** ☐ **Road Signage** ☐ **School** ☐ **Newspaper** ☐ **Other**_____ **Referral** ***(below)***

I was referred by (name)

Occupation: Employer:

In case of an emergency, who can we contact?

Name: Relationship to you:

Phone:

Doctor's Name (GP): Practice:

If you are under 18:

Parent's Name: Parent's Phone:

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? -

What do you use to clean your teeth at home?

Are any of your teeth sensitive to: Hot **YES** ◯ **NO** ◯ Cold **YES** ◯ **NO** ◯ Biting/Chewing **YES** ◯ **NO** ◯

Have you ever had:

Orthodontics (braces)	YES ◯	NO ◯
Gum treatment	YES ◯	NO ◯
An injury to your teeth or jaws	YES ◯	NO ◯
A bad dental experience	YES ◯	NO ◯
Dental infections/abscess	YES ◯	NO ◯
Any teeth extracted	YES ◯	NO ◯

Have you ever been aware of?

Sore or bleeding gums	YES ◯	NO ◯
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 ◯

Please Turn Over →

Would you like more information about:

Whitening your teeth	YES ◯	NO ◯
Straightening your teeth	YES ◯	NO ◯
Replacing missing teeth	YES ◯	NO ◯

Any other dental treatment: _____

SECTION THREE: YOUR MEDICAL HISTORY

Are you currently taking any medications? YES ◯ NO ◯
If **YES**, which medicines:

Are you aware of any allergies or adverse reactions that you have? YES ◯ NO ◯
If **YES**, details:

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

Heart Trouble	YES ◯	NO ◯	Stroke	YES ◯	NO ◯
High Blood Pressure Blood	YES ◯	NO ◯	Sinusitis	YES ◯	NO ◯
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 ◯

Have you ever had, or are you being treated for any condition not listed above? YES ◯ NO ◯

If **YES**, please describe: _____

Have you been vaccinated against Covid-19? YES ◯ NO ◯

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

Do you smoke? YES ◯ NO ◯ If **YES**, amount per day _____ If NO, have you ever smoked? YES ◯ NO ◯

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

If **YES**, details: _____

Women: Are you pregnant? YES ◯ NO ◯ If **YES**, number of months _____

SECTION FOUR: OUR AGREEMENT

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Please check this box if you do not wish to receive the practice newsletter with important information and updates

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 priority.
YOUR COMMITMENT: I agree that I am responsible for payment of all services 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. All costs incurred in the recovery of overdue funds including but not limited to debt recovery costs and legal fees will be added to the balance of your account. I understand that by making appointments with McIntosh Dental Centre I am agreeing to attend the appointments or to give a minimum of 48 hours' notice of cancellation of appointments. If I fail to attend an appointment, a 'no-show' fee may be charged.

Signed _____ Date _____ Checked _____