PERSONAL & HEALTH PROFILE

MANY THINGS HAVE A BEARING ON YOUR DENTAL HEALTH. THE ANSWERS TO THE FOLLOWING QUESTIONS ARE IMPORTANT FOR ME TO BE EFFECTIVE AND EFFICIENT IN TAILORING THE BEST SERVICE AND CARE FOR YOU. ANY INFORMATION YOU GIVE ME IS STRICTLY CONFIDENTIAL ON A NEED TO KNOW BASIS WITHIN THIS PRACTICE AND WILL NOT BE GIVEN TO ANYONE WITHOUT YOUR PERMISSION. WELCOME TO MY PRACTICE.

A Smiling Place *Dr Suresh Rashid BDSc,GradDipAppSc(Comp)*

PERSONAL INFORMATION

MR / MRS / MS / MISS / MSTR / DR / Other _____ DENTAL INSURANCE CO. _____

SURNAME FIRST NAME INITIALS PREFERRED NAME

POSTAL ADDRESS SUBURB POSTCODE

RESIDENTIAL ADDRESS SUBURB POSTCODE

OCCUPATION / PLACE OF WORK (SCHOOL) / ADDRES SUBURB POSTCODE

NEXT OF KIN NOT LIVING WITH YOU / RELATIONSHIP / ADDRESS SUBURB POSTCODE

DATE OF BIRTH / /

WHO MAY WE THANK FOR REFERRING YOU TO OUR CARE?

PAYMENT:

PERSON RESPONSIBLE FOR PAYMENT ?SELF / OTHER (IF OTHER *)

/ /

DATE / SIGNATURE /(*IF OTHER THAN SELF,STATE NAME & RELATIONSHIP TO PATIEN

PLEASE NOTE THAT ALL ACCOUNTS ARE DUE AND PAYABLE AT THE END OF EACH VISIT. ACCOUNTS OUTSTANDING FOR COMPLETED SERVICES MAY ATTRACT ADDITIONAL ADMINISTRATIVE ACCOUNT KEEPING AND RECOVERY FEES. THANK YOU FOR YOUR COOPERATION.

CONTACT:

	WORK	HOME	MOBILE	?
TELEPHONE NOS.				
PREFERENCE ORDER (i.e. 1 / 2 / 3 / 4)				
BEST TIMES TO CALL				
CONTACT NAME				

(If silent, please advise....)

BEST PLACE TO BE CONTACTED: WORK / HOME / MOBILE / EMAIL / FAX / OTHER

EMAIL ADDRESS:

AVAILABILITY:

WHAT IS YOUR APPOINTMENT AVAILABILITY?
ANYTIME / REASONABLE * / RESTRICTED *

DO YOU HAVE ANY URGENCY IN NEEDING YOUR TREATMENT COMPLETED ? YES / NO

IF YES, IS IT BECAUSE OF TIME / PAIN

DO YOU EVER HAVE DAYS OFF? YES / NO

* WHAT TIMES ARE GOOD AND BAD FOR YOU?

/-GOOD; X -BAD	Mo	Tu	We	Th	Fri	Sa
< 9 am						
9 - 12						
12 - 1						
1 - 2						
2 - 5						
> 5 pm						

What is the main reason for your visit today? _____

HOW CAN WE SERVE YOU BETTER? PLEASE RATE YOUR PRIORITIES BELOW (1/2/3/4) ....

☐ COMFORT ☐ THOROUGHNESS ☐ TIME ☐ COST

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...../2

MEDICAL HISTORY

NAME OF DOCTOR/PHYSICIAN LAST VISIT ADDRESS

HAVE YOU **EVER** HAD OR DO YOU **CURRENTLY** HAVE ANY OF THE FOLLOWING

HEART PROBLEMS	Y	N	COMMON ALLERGIES (EG. RUBBER / METALS / JEWELLERY)	Y	N
LUNG PROBLEMS	Y	N	DRUG ALLERGIES (EG. PENICILLIN / ASPIRIN / CODEINE)	Y	N
KIDNEYS / LIVER PROBLEMS	Y	N	ASTHMA	Y	N
DIGESTIVE PROBLEMS (EG. ULCERS / REFLUX / DRY MOUTH)	Y	N	ARTHRITIS OR A FAMILY HISTORY OF ARTHRITIS	Y	N
SENSORY PROBLEMS (HEARING / SIGHT / TOUCH / TASTE / BALANCE)	Y	N	DIABETES OR A FAMILY HISTORY OF DIABETES	Y	N
MOTOR PROBLEMS (MOVEMENT)	Y	N	HEPATITIS (A / B / C / OTHER)	Y	N
BLEEDING / CLOTTING PROBLEMS	Y	N	EPILEPSY	Y	N
BLOOD CIRCULATION PROBLEMS	Y	N	DO YOU SMOKE ? /DAY/WEEK	Y	N
BLOOD PRESSURE PROBLEMS (HIGH / LOW)	Y	N	RHEUMATIC FEVER	Y	N
NECK OR BACK INJURIES OR DISCOMFORT	Y	N	ARTIFICIAL JOINTS	Y	N
SINUS AILMENTS (EG. HAYFEVER / BLOCKED SINUSES / DIFFICULTY NOSE BREATHING (R / L))	Y	N	HAVE YOU EVER BEEN IN HOSPITAL FOR MORE THAN A WEEK ?	Y	N
IF YOU SNORE, IS IT A PROBLEM FOR YOU ?	Y	N	CURRENTLY, ANY INFECTIOUS DISEASE / AILMENT	Y	N
TUMOUR / CANCER / RADIOTHERAPY ?	Y	N	IN THE LAST 3 WEEKS, FLU / HEAD COLD	Y	N

ARE YOU CURRENTLY ON ANY MEDICATION ? IF SO, PLEASE SPECIFY

IF FEMALE : ARE YOU PREGNANT ?	Y	N	IF SO, HOW PREGNANT ARE YOU ? WKS		
ARE YOU BREAST FEEDING ?	Y	N	IF NOT, COULD YOU BE PREGNANT / ARE YOU TRYING TO GET PREGNANT?	Y	N

DENTAL HISTORY

DO YOU SUFFER ANY DISCOMFORT IN THE NECK / FACE / HEAD AREAS ?	Y	N	DO YOUR JAW JOINTS (IN FRONT OF YOUR EARS) EVER CLICK / GRATE / POP OR LOCK ?	Y	N
ARE ANY OF YOUR TEETH / GUMS / TONGUE / PALATE / LIPS / CHEEKS SORE ?	Y	N	HAVE YOU EVER HAD ANY PAIN ASSOCIATED WITH THE ABOVE ?	Y	N
DO YOU HAVE ANY SENSITIVITY TO : HEAT	Y	N	HAVE YOU EVER HAD ANY ACCIDENTS WITH YOUR TEETH OR JAWS ?	Y	N
COLD	Y	N	ARE YOU AWARE IF YOU CLENCH OR GRIND YOUR TEETH WHEN YOU ARE AWAKE / ASLEEP ?	Y	N
SWEET	Y	N	CAN YOU CONFIDENTLY AND COMFORTABLY CHEW SOLID FOODS ?	Y	N
EATING	Y	N	IS THERE ANYTHING ABOUT YOUR TEETH YOU'D LIKE TO CHANGE ? (EG. SHAPE / COLOUR / POSITION)	Y	N
CLENCHING	Y	N	HAVE YOU EVER HAD ANY PROBLEMS ASSOCIATED WITH A DENTAL VISIT ?	Y	N
ARE YOU AWARE OF ANY CAVITIES IN YOUR TEETH?	Y	N	DO YOUR GUMS EVER BLEED WHEN YOU ARE BRUSHING / FLOSSING / EATING / OTHER ?	Y	N
CAN YOU EASILY TASTE YOUR FOOD ?	Y	N	DO YOU BRUSH YOUR TEETH ? /DAY/WEEK	Y	N
DO YOU EVER GET A BAD TASTE IN YOUR MOUTH ?	Y	N	DO YOU FLOSS YOUR TEETH ? /DAY/WEEK	Y	N
HAS ANYONE EVER COMPLAINED ABOUT OR ARE YOU UNCOMFORTABLE ABOUT YOUR BREATH ?	Y	N	WOULD YOU LIKE TO LEARN WHAT YOU CAN DO TO MINIMIZE YOUR DENTAL PROBLEMS AND VISITS ?	Y	N

WHEN DID YOU LAST HAVE A THOROUGH DENTAL EXAMINATION_____ MTHS./YRS.

IF LESS THAN 2 YEARS, NAME AND ADDRESS OF DENTIST_____

IF YOU HAVE LEFT YOUR PREVIOUS DENTIST, WHY DID YOU LEAVE?_____

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Thank You.

SIGNATURE

1	2	3	4	5
6	7	8	9	10

LAST UPDATE