gentledental CENTRE

Gentle, professional, family friendly dental care

Dr Sherry Wong BDSc (UWA)
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PERSONAL INFORMATION

Name _____ _____ _____
Title First name Surname Preferred name

Address _____ _____ _____
Suburb Postcode

Date of Birth _____ Phone M _____ W _____ H _____

Email _____ Occupation _____

Name of person responsible for payment of account (if not self): _____

Has spouse/family member been to Gentle Dental Centre before? ☐ Yes ☐ No

How did you hear about Gentle Dental Centre? ☐ Google ☐ Yellow Pages ☐ Sign on the road

☐ Friend or relative _____ ☐ Other _____

Do you have private health insurance? ☐ Yes _____ ☐ No
Health fund

Contact details in case of emergency

Name _____ Relationship to patient _____

Contact phone M _____ W _____ H _____

MEDICAL HISTORY

Medical Practitioner _____ _____ _____
Name Medical Centre Phone

Specialist details (for those with ongoing specialist treatment) Condition _____

Specialist _____ _____ _____
Name Medical Centre/Hospital Phone

Are you **allergic** to any of the following? (please tick all that apply) ☐ No allergies

☐ Penecillin ☐ Latex ☐ Codeine ☐ Chlorhexidine ☐ Tramadol ☐ _____
Other

Any other medications that you are unable to take? _____

Are you a smoker? ☐ No ☐ No, I quit _____ ☐ Yes _____ _____
Congrats! How long ago? How long for? How many per day?

Do you require antibiotics before dental treatment? ☐ Yes ☐ No ☐ Not sure

Females:
Are you pregnant? ☐ No ☐ Yes (when are you due?) _____
Are you breastfeeding? ☐ No ☐ Yes

Please turn over

Please tick Yes or No if you have EVER had history of the following:

	Yes	No
Heart problems	☐	☐
Heart transplant	☐	☐
Pacemaker	☐	☐
Heart valve replacement	☐	☐
Congenital heart disease	☐	☐
Rheumatic fever	☐	☐
Previous infective endocarditis	☐	☐
Stroke or heart attack	☐	☐
High or low blood pressure	☐	☐
Excessive brusing or bleeding	☐	☐
Blood disorders	☐	☐
Diabetes (☐ Type I or ☐ II)	☐	☐
Artificial joints/pins/plates	☐	☐
Reflux	☐	☐
Arthritis	☐	☐
Osteoporosis	☐	☐
Musculoskeletal disorders	☐	☐

	Yes	No
Hep A, B, C or liver disease	☐	☐
Epilepsy/seizures	☐	☐
Neurological disorders	☐	☐
Thyroid disease	☐	☐
Snoring/sleep apnoea	☐	☐
Psychiatric/psychological disorders	☐	☐
Asthma or lung problems	☐	☐
Cancer _____ (When and what type)	☐	☐
Radiation therapy _____ (What part of body)	☐	☐
Do you suffer from any other illness not listed above? (Please provide details):	☐	☐

_____

_____

MEDICATIONS

Please list any medications (including over the counter or supplements).

Name of medication Purpose (eg for diabetes, blood thinner, osteoporosis, asthma)

_____

_____

_____

Please provide list if you have more medications and we will scan it in.

DENTAL HISTORY

How do you feel about dental visits?

☐ Love them! ☐ Not fussed ☐ A little apprehensive ☐ Anxious ☐ Extremely nervous

When was your last visit to the dentist? _____

Please tick if you have ever had history of the following:

☐ Grinding/clenching teeth
☐ Jaw locking or pain on opening
☐ Gum disease
☐ Sensitive teeth
☐ Oral abscesses
☐ Dry mouth
☐ Needing extra local anaesthetic to become numb
☐ Difficulty lying back in the dental chair

What type of toothpaste do you use ☐ Regular ☐ Sensitive ☐ Non fluoride (herbal) ☐ Other_____

Payment is required on the day of treatment unless otherwise arranged by the dentist or practice manager. In the event of an account being in default, the customer shall be liable for all resulting costs arising from the recovery. This includes commission which would be payable if the account is paid in full and legal costs including demand costs. Full trading terms are detailed on our website or a copy is available from reception upon request.

I declare that the above history is true and correct. I agree to the above trading terms.

Patient or guardian signature: _____ Date: _____