Welcome to Rawson Dental!

Thank you for giving us the opportunity to care for your oral health and smile. In order to provide high standard of care and treatment, please review and complete the following questionaire. It will be handled confidentially.

Title: First Name:	Surname:
Date Of Birth:	Address:
Postcode:	Home Number:
Work Number:	Mobile Number:
Email:	Occupation:
Emergency Contact:	Private Health Fund: Member Number:
If <18yrs, parent /responsible party:	

How did you hear about the Practice? (Please circle)

Internet/Website Yellow Pages Walked past Letter Drop

Dentist/ Doctor: Other: Recommended by:

Is another member of the family a patient at our office:

What is the main purpose of your visit today?

Name of your **G.P**: Phone:
Address:

Have you had any of the following **Medical Issues**? please tick

Heart Problems / Disease	Yes	Allergies to Anaesthetic / Latex	Yes
Blood Pressure	Yes	Allergies to Penicillin	Yes
Artificial Joints	Yes	Allergies to Medications	Yes
Rheumatic Fever	Yes	Sinus Problems	Yes
Heart Valve replaced/leaky	Yes	Anaemia or other blood problems	Yes
Circulatory Problems	Yes	Diabetes	Yes
Excessive Bruising /Bleeding	Yes	Asthma	Yes
Liver or Kidney Disease	Yes	Epilepsy	Yes
Radiation Treatment	Yes	Hepatitis A, B, C or D	Yes
Stomach Ulcers	Yes	Tuberculosis or CJD or HIV or AIDS	Yes
Cancer	Yes	Infectious Diseases	Yes
Sleep Apnoea	Yes	Dizziness/Fainting	Yes
Psychological Disorder	Yes	On Warfarin	
Are you Pregnant?	Yes	if so, what is your due date?	

Are you currently taking any **medications**? Are you taking or have you taken any Bisphosphonate drugs? If YES please provide details

Have you had any of the following **dental issues**? please circle

Does your jaw click or hurt?	Yes	Do you smoke?	Yes
Do you feel you grind your teeth?	Yes	Bad Breath?	Yes
Orthodontic Treatment?	Yes	Bleeding Gums	Yes
Do you wear a guard at night?	Yes	Pain on bitting hard?	Yes
Sensitivity to hot or cold?	Yes	Food jamming between teeth?	Yes
Have you had gum Disease?	Yes	Problems flossing?	Yes

Other Notes or Concerns you would like us to know about?

How long since your last dental visit?

How often do you have dental examinations?

Previous dental xrays were taken: Less than a year ago? Longer than a year ago?

Consent for Treatment

I hereby authorise the dentist or designated team to take x-ray, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand I can ask for a complete recital of any complications associated with treatment I may need. I agree to be responsible for payment of all sevices rendered on my behalf and on behalf of my dependents. I understand that payment is due at the end of service unless other arrangements have been made. I authorise that this information may be reviewed by team members of the dental practice.

Signature: Date:

Name: