

AUSTRALIAN UNITY DENTAL CARE

ABN 80 109 450 991

Dental Registration Form

Please answer all questions. All information is strictly confidential.

Title: _____ First Name: _____ Initial: _____ Family Name: _____

Address: _____

_____ Post Code: _____

Date of birth: _____ Home Phone No: _____

Mobile No: _____ Work No: _____

Email address: _____

Occupation: _____ Business Name: _____

Emergency Contact: _____ Phone No: _____

Person responsible for payment: _____

Who is your current or previous dentist? _____

Who is your medical doctor? _____ Phone No: _____

Do you have Dental Insurance? (please circle) Yes No

Which Health Fund? (please circle) Australian Unity Other: _____

Membership number: _____ Level of Cover (if known): _____

TERMS: STRICTLY PAYMENT ON THE DAY, PLEASE

"I acknowledge that the personal information collected from me by Australian Unity Health Care Limited ("Australian Unity") is collected for the purpose of allowing Australian Unity to provide services to me, and that if I do not provide relevant information, Australian Unity may be unable to provide those services. I acknowledge that my information may be disclosed in part or full in accordance with statutory requirements, including disclosure to government and health organisations. I acknowledge that I am aware that I have rights to access my personal information held by Australian Unity in accordance with the National Privacy Principles".

SIGNED: _____ DATE: _____

Medical Questionnaire

The state of your health may have a very significant effect on your dental care and is essential in appropriate treatment planning.

Please answer all questions. Please circle Yes or No, and give details where asked.

***I have private and confidential medical matters that I wish to discuss with the dentist?** **Yes** **No**

- | | | | |
|-----|---|------------|-----------|
| 1. | Are you receiving any medical treatment at present? | Yes | No |
| 2. | Have you ever been hospitalised for any illness? | Yes | No |
| 3. | Ever had any type of heart (cardiac) complaint/treatment? | Yes | No |
| 4. | Do you have a heart murmur? | Yes | No |
| 5. | Do you have a cardiac pacemaker? | Yes | No |
| 6. | Do you have high blood pressure? | Yes | No |
| 7. | Do you have low blood pressure? | Yes | No |
| 8. | Do you have bleeding problems? | Yes | No |
| 9. | Are you taking anticoagulants (blood thinners)? | Yes | No |
| 10. | Do you suffer from excessive bruising or bleeding? | Yes | No |
| 11. | Do you have kidney or liver problems? | Yes | No |
| 12. | Have you ever had Rheumatic Fever? | Yes | No |
| 13. | Do you have asthma? | Yes | No |
| 14. | Do you suffer from shortness of breath? | Yes | No |
| 15. | Do you faint easily? | Yes | No |
| 16. | Do you have diabetes? | Yes | No |
| 17. | Is there any history of diabetes in the family? | Yes | No |
| 18. | Do you have osteoporosis or other bone related conditions? | Yes | No |
| 19. | Do you have any type of artificial valve, prosthetic hip, etc? | Yes | No |
| 20. | Have you ever tested positive for tuberculosis? | Yes | No |
| 21. | Do you have AIDS/HIV or ever tested positive for the virus? | Yes | No |
| 22. | Do you have any type of Hepatitis? Details _____ | Yes | No |
| 23. | Do you suffer from Epilepsy, convulsions or seizures? | Yes | No |
| 24. | Do you have now or ever had cancer or leukaemia? | Yes | No |
| 25. | Have you ever had radiation therapy? | Yes | No |
| 26. | Do you have thyroid disease? | Yes | No |

Do you smoke? **Yes** **No** Please circle type: cigarettes/ cigars/ pipes/ other?

If yes, for how long? _____ How much do you smoke per day? _____

Did you know that if you smoke, you have more problems with gum disease and their treatments and have a higher risk of losing dental implants? **Yes** **No**

Please list any medications or drugs, including aspirin, bisphosphonate, hormone replacement therapy, vitamins, herbal, naturopathic or 'over the counter' remedies you are taking _____

Please circle any of the following to which you are allergic?

- | | | | | | |
|------------|----------|--------------|--|----------|-----------|
| Penicillin | Aspirin | Tetracycline | Erythromycin | Keflex | Xylocaine |
| Valium | Morphine | Novocaine | Codeine | Duranest | Foods |
| Latex | Chlorine | Other | Antiseptics or chemicals, (please list): _____ | | |

Females:

Are you pregnant? Yes No Due date: _____

Are you taking birth control pills? **Yes** **No**

Are you breastfeeding? Yes No

Dental Questionnaire

- | | | | | | |
|-----|--|-----------|--------|------|-------------|
| 1. | How would you describe your dental health? | Excellent | Good | Fair | Poor |
| 2. | What do you use to clean your teeth at home? | Brush | Floss | | Mouth rinse |
| 3. | What type of toothbrush do you use? | Hard | Medium | | Soft |
| 4. | (i) When was your last dental check up? | _____ | | | |
| | (ii) When were your last dental x-rays taken? | _____ | | | |
| 5. | Have you ever had orthodontic (braces) treatment? | | Yes | | No |
| 6. | Are your teeth sensitive to hot or cold? | | Yes | | No |
| 7. | Do you clench or grind your teeth? | | Yes | | No |
| 8. | Do you get food trapped between your teeth? | | Yes | | No |
| 9. | Do you get clicking or pain in your jaw? | | Yes | | No |
| 10. | Do your gums bleed? | | Yes | | No |
| 11. | Do you get bad taste or bad breath? | | Yes | | No |
| 12. | Do you get mouth ulcers? | | Yes | | No |
| 13. | Would the loss of a tooth or teeth disturb you? | | Yes | | No |
| 14. | Have you ever had a bad experience at the dentist? | | Yes | | No |

Cosmetic Evaluation

- | | | | |
|----|---|------|----|
| 1. | Are you happy with the appearance of your teeth? | Yes | No |
| 2. | Are you happy with your smile? | Yes | No |
| 3. | Would you like to have whiter teeth? | Yes* | No |
| 4. | Would you like an explanation regarding fresh breath therapy? | Yes* | No |
| 5. | Do you have existing amalgam fillings that you want to replace with white ones? | Yes* | No |
| 6. | Would you like straighter teeth? | Yes* | No |

* If you answered yes to any of the above questions, we can help give you a better, more beautiful smile.

What is the purpose of your visit? _____

We thank you for taking the time to fill out this form, and for giving us the opportunity to look after you. We will endeavour to provide you with the best care, skill and judgement. Please read the statement below and sign where indicated.

In signing this form I acknowledge that this represents an accurate medical and dental history. I will advise my dentist of any changes in the future.

SIGNED: _____

DATE: _____