Pymble Dental Practice

ACQUAINTANCE FORM

Welcome to our practice. Please take the time to answer these questions as completely as possible. This will assist us greatly in our efforts to provide the best dental treatment for you. Thank You.

NAME: Title: …… Given Names:…… Surname:……..

Preferred Name …… Date of Birth: ……../……../……

ADDRESSES:

Private Address: ……

…… Postcode: ……..

Business Name & Address:……

……Postcode: ……..

Email:……

Occupation ……

School/University ……Year ……..

Do You Have Dental Health Insurance?……..

PHONE NUMBERS:

Best Daytime Contact No: ……

Mobile :……

Home Phone: ……

Business Phone:……

Emergency Contact Person:……

Relationship:……..Phone:……

Who Referred You to This Practice?……..

Name of Health Fund:…… Your Line No:……

What factors influenced your decision to attend this Practice? ……..

At Pymble Dental we remind our patients of their appointments – please indicate the preferred means of contact:
☐ SMS to mobile ☐ Call mobile ☐ Call home phone ☐ call work phone

MEDICAL HISTORY	NO	YES	COMMENTS
Have you ever had **heart** trouble, heart surgery, Rheumatic Fever, Epilepsy or high blood pressure?			
Have you ever had Diabetes, Hyperthyroidism, Asthma, Glaucoma, nervous disorders, Anaemia, Bone disorders or Tuberculosis			
Have you ever had **Cancer** or any other **serious illness**? Radiation treatment or Chemotherapy?			
Have you been a patient in **hospital** during the past two years?			
Are you under current **medical treatment?**			
Do you **Smoke**? How many per day?			
Are you taking any **drugs or medicines?** Please list.			
Are you taking (or have you ever taken) **Aredia, Zometa**, **Fosamax** or **Actonel** (usually for Osteoporosis)?			
Do you normally take **Antibiotics** prophylactically before a dental appointment?			
Do you have any **artificial hips, heart valves or pacemakers?**			
Have you any known **allergies** to drugs (especially penicillin), medicines or antiseptics?			
Have you ever experienced prolonged **bleeding?**			
Have you had, or do have **Hepatitis** or **any blood borne diseases?**			
Have you ever had **Kidney, Liver** or **Stomach** disease?			
Women: Are you, or might you be, **pregnant?**			
Who is your General Medical Doctor?	Phone No:		

DENTAL HISTORY	NO	YES	COMMENTS
Does **food catch** between your teeth			
Are your **experiencing any sensitivity** …….hot, cold, sweet, chewing or biting pressure?			
Do your **gums bleed** when brushing?			
Do you have any **bad taste** or odours in your mouth?			
Do you have any concerns with the **appearance of your teeth or their colour?**			

List **previous problems** with **Dental Treatment**:……

Main dental **reason for your visit today**?……...

When was your **last dental visit**?……

Do you have any **incomplete treatment** from your previous dentist ……

Any further **comments or special requests**?……

……..

Person responsible for **payment today**?……

Privacy: All information will be treated with privacy and confidentiality as per Commonwealth Government Privacy Act 2002
This includes advising all treating practitioners of relevant medical and dental conditions.

Signature …….. Date ……/……../……