

Welcome to No Gaps Dental

In order to provide you with safe and efficient dental care, it is necessary to collect the following information from you. We respect your privacy and information provided will be kept confidential in accordance to the Privacy Act 2000. Our Privacy Policy can be found at the back of your clipboard and on our website.

PERSONAL DETAILS										
Title:	<input type="checkbox"/> Dr	<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Ms	<input type="checkbox"/> Master	<input type="checkbox"/> Miss	Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other
Surname:	First Name:			Date Of Birth:						
Address:	Suburb:			Postcode:						
Home No.:	Mobile No.:									
Are you an interstate or overseas visitor to Sydney				<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is English your first language?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Occupation:				Work No.:						
What is your highest level of education?										
E-mail address:										
Do you have a Private Health Fund?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, Name of the fund:				
Membership No.:				ID# on card (1, 2, 3 etc):						
Medicare No.:				ID# on card (1, 2, 3 etc):						
How did you find out about No Gaps Dental?										
Google	<input type="checkbox"/>	Facebook / Instagram	<input type="checkbox"/>	Health Fund	<input type="checkbox"/>	Radio:				
Website	<input type="checkbox"/>	Family / Friends	<input type="checkbox"/>	Signage	<input type="checkbox"/>	KIIS 106.5		<input type="checkbox"/>		
Other (please specify):						Smooth fm 95.3		<input type="checkbox"/>		
						Other / Unsure		<input type="checkbox"/>		
Person to contact in the case of emergency:										
Relationship to patient:										
Contact No.:				Mobile No.:						
Your GP's Name:										
Address:										
Contact No.:										

DENTAL HISTORY										
When was the last time you visited the dentist?				<input type="checkbox"/> 6mths	<input type="checkbox"/> 1yr	<input type="checkbox"/> 18mths	<input type="checkbox"/> 5yrs	<input type="checkbox"/> more than 10yrs		
Do you have prolonged/excess bleeding after an extraction?				<input type="checkbox"/> Yes	<input type="checkbox"/> No					
How often (daily) do you brush your teeth?				<input type="checkbox"/> once	<input type="checkbox"/> twice	<input type="checkbox"/> 3 times	<input type="checkbox"/> do not brush			
How often (daily) do you floss your teeth?				<input type="checkbox"/> once	<input type="checkbox"/> twice	<input type="checkbox"/> 3 times	<input type="checkbox"/> do not floss			
What dental problems do you experience?										
Bleeding gums	<input type="checkbox"/>	Painful/sore gums	<input type="checkbox"/>	Swollen gums	<input type="checkbox"/>	Sharp teeth	<input type="checkbox"/>			
Bad breath	<input type="checkbox"/>	Sensitivity to hot/cold	<input type="checkbox"/>	Grinding your teeth	<input type="checkbox"/>	Clenching your jaw	<input type="checkbox"/>			
Tooth discolouration	<input type="checkbox"/>	Other (Please specify):								
If you have ever had a bad dental experience, what was it?										
What other way/s are you dissatisfied with your teeth?										

MEDICAL HISTORY

Do you suffer or have you ever had any of the following medical conditions or treatments:

	Present	Past	Never		Present	Past	Never
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Steroid Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High / Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other conditions (please provide details):

Are you allergic to any of the following:

	Yes	No		Yes	No
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>
Codine	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>
EES Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Panadol	<input type="checkbox"/>	<input type="checkbox"/>
Epilim	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>

Other allergies (please provide details):

If female, are you pregnant? Yes Approx. due date _____ NoAre you taking / or have you ever taken any bisphosphonates (ie. Fosamax, Prolia, etc)? Yes NoAre you taking anticoagulants (aspirin)? Yes No

What medication/s are you currently taking?

What medical treatment you are currently under?

Do you smoke? Yes No Do you use recreational drugs/controlled drugs Yes No **I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist about this**

I have answered all the questions to the best of my knowledge and understand that it is my responsibility to inform the surgery about any changes to my medical health and personal details. If further information is required, I give my permission for the surgery to contact my general practitioner. I have read and accept the privacy policy. I understand and accept that a cancellation fee will apply if I do not provide a minimum of 24hours notice of not being able to attend my appointment. I agree to assume complete financial responsibility for my account and understand that **full payment is required on or before the day of treatment**. I understand and agree that in the event of my account remaining unpaid and being referred to a debt collection agency and/or law firm, all collection and legal demand costs will be added to my account for which I am responsible for.

Signature: _____

Date: _____

Any patient under the age of 18yrs old must have a consenting adult sign this form

Name of consenting adult (Please PRINT): _____

Thank you for taking the time to complete this form