Morgan Street Dental Centre – Patient Details

So we can ensure we are looking after your needs, please review and complete the following questionnaire:

Surname: (Mr / Mrs / Miss / Ms / Master / Dr)	**First Name:**
Date of Birth:	**Home Phone:**
Mobile:	**Work Phone:**
Residential Address:	**Postal Address (if different from residential address):**
Occupation:	**Email:**
Person responsible for fees:	**Address:**

Emergency Contact: Name: ____________________ Phone No: ________________ Relationship: ______________________

How were you referred to this practice? (eg. friend/yellow pages)____________Recommended by: ____________________

Is another member of your family a patient at our office? ○ Yes ○ No

Dental insurance company: ______________ Membership Number: ______________________ Line Number: _________

Department of Veterans' Affairs Number (for Gold Card Holders Only): ____

Medicare Number: _________________________________ Line Number: ____

Have you had any of the following?

Hepatitis A / B / C / D / E	**○Yes**	**Allergies to penicillin**	**○Yes**
Diabetes	**○Yes**	**Allergies to medications**	**○Yes. If yes, please specify: ________________________**
High blood pressure	**○Yes**	**Allergies to latex**	**○Yes**
Excessive bleeding	**○Yes**	**Heart Problems**	**○Yes. If yes, please specify: ________________________**
Excessive Bruising	**○Yes**	**Do you smoke?**	**○Yes. If yes, how many daily? ______________________**
Tumor History	**○Yes**	**Asthma**	**○Yes**
Radiation Treatment	**○Yes**	**Anemia**	**○Yes**
Liver problems	**○Yes**	**Blood disorders**	**○Yes**
Gastro-oesophageal reflux	**○Yes**	**History of dry socket**	**○Yes**
HIV / AIDS	**○Yes**	**Osteoporosis**	**○Yes. If yes, do you take Fosamax? ○Yes**
Stomach ulcers	**○Yes**	**Kidney problems**	**○Yes**
Artificial joints	**○Yes**	**Rheumatic fever**	**○Yes**
Epilepsy	**○Yes**	**Circulatory problems**	**○Yes**
Are you breast feeding?	**○Yes**	**Are you pregnant?**	**○Yes. If yes, what is the due date? _________________**

Name of your physician: ________________________________Address: ____

Are you currently taking any medications? Please specify: ____

(please turn over)

Purpose of visit: ____

Have you had any of the following?

Do you experience sensitivity with hot/cold?	**○Yes**	**Do you feel nervous about dental visit?**	**○Yes**
Do your teeth ever hurt when you bite hard?	**○Yes**	**Does your jaw click or hurt?**	**○Yes**
Do your gums bleed when you brush your teeth?	**○Yes**	**Do you feel you grind your teeth?**	**○Yes**
Do you think you have occasional bad breath?	**○Yes**	**Do you wear a night guard?**	**○Yes**
Does floss ever tear between your teeth?	**○Yes**	**Have you ever had orthodontic treatment?**	**○Yes**
Does food get jammed between your teeth?	**○Yes**	**Do you bite your lips or cheek often?**	**○Yes**
Have you ever had gum disease?	**○Yes**	**Have you ever had your bite adjusted?**	**○Yes**

Other Notes: ____

How long since your last dental appointment? ____

How often do you have dental examinations? ____

Previous dental x-rays were taken: ○ Less than a year ago ○ Longer than a year

Would you give your consent for Morgan Street Dental Centre to use your clinical photographs (mouth only) for educational and training purposes? ○Yes ○No

Consent for Treatment and Payment

I hereby authorise the dentist or designated team to take x-rays, 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.

By signing this document I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand that payment is due at the time of treatment. In the event of this 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 the account.

Please be aware that Morgan Street Dental Centre has a 24 hour cancellation/rescheduling Policy. If you cancel/reschedule an appointment at short notice or cancel/reschedule often you may be asked to pay a holding deposit before we can schedule your next appointment.

Patient signature: ______________________________**Date:** ____________________________

Parent / guardian's signature: __________**Relationship to patient:** ____________________