Gentle Touch DENTAL

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Health History / New Patient Form:

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

Surname:	First name: (Mr/ Mrs/ Miss/ Ms/ Dr):
Date of birth:	Address:
Recommended by:	Home phone:
Work Phone:	Mobile:
Email:	Occupation/Employer:
Name of person responsible for fees, if not self:	Address:

Purpose of visit: _____

Dental insurance company:_____

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

How did you find out about us?

Please tick box if you have/ had previously any of the following:

- ☐ Heart problems
- ☐ High blood pressure
- ☐ Artificial joints
- ☐ Rheumatic fever
- ☐ Circulatory problems
- ☐ Radiation treatment
- ☐ Excessive bleeding
- ☐ Excessive bruising Ulcers (stomach)
- ☐ Sinus Trouble
- ☐ Tumor History
- ☐ Allergies to anaesthetic
- ☐ Allergies to penicillin
- ☐ Allergies to medications
- ☐ Allergies to latex
- ☐ Anemia or other blood disorders
- ☐ Diabetes
- ☐ Asthma
- ☐ HIV
- ☐ Hepatitis A / B / C / D / E
- ☐ Epilepsy
- ☐ Liver or kidney problems

Are you currently taking any medications? Yes No

If **yes**, please list: _____

See next page...

Have you had any of the following?

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

Other Notes:

_____

_____

Name of your Physician: _____

Phone: _____

Address: _____

Are you pregnant? If so, what is your due date? _____

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 ago

Consent for treatment

I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and other diagnostics aids deemed appropriate by the dentist to make at thorough diagnosis. Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service. I understand and agree to pay the non-refundable cancellation payment of $75.00 if I cancel my appointment within the 24 hour period as per the cancellation policy.

I authorise that this data may be reviewed by team members of the dental practice.

Patient signature: _____ Date: _____

Parent/responsible party's signature: _____

Relationship to patient: _____

We thank you for understanding.