Dental at Lake Haven
76 Goobarabah Ave
Lake Haven NSW 2259
Ph: 43926466 **Fax:** 49927565
Email: admin@dentalatlakehaven.com.au
Website: www.dentalatlakehaven.com

Dental at Kanwal
Suite C6, Kanwal Medical Complex
654 Pacific Hwy, Kanwal, NSW 2259
Ph: 43930020 Fax: 43930024
Email: dentalatkanwal@exemail.com.au
Website: www.kanwaldental.com

Welcome to our Practice! Please answer these questions as completely as possible. It will assist us greatly in our effort to provide the best dental treatment for you.

Full Name: Mr / Mast / Mrs / Miss / Ms

Address: _____

Suburb: _____ Postcode: _____

Mobile: _____Ph Work _____ Ph Home _____

Date of birth _____ Occupation _____

Email address _____

Person responsible for fees _____

Emergency contact – Name _____ Contact No _____

What dental insurance or benefit do you have? _____

MEDICAL HISTORY

Who is your medical doctor? _____ Ph No _____

Have you had any serious health problems during the past year?

_____

_____

Do you take prescribed medication regularly? _____ If yes, please list names of all medications.

_____

Do you take blood thinning medication eg.. warfarin, aspirin _____

Have you ever had excessive bleeding whilst in the dental chair?_____

Are you allergic to Penicillin or any other medication or Foods? _____

Do You Or Have You Ever Suffered From Any Of The Following? (Please circle)

□ Heart/Vascular Disorder	□ Asthma □ Reflux	□ Diabetes 1 or 2
□ High /Low Blood Pressure	□ Breathing difficulties	= Epilepsy, seizures
□ Rheumatic Fever	□ Hepatitis A B C	□ mouth Ulcers lumps, spots of concerns
□ Glandular fever	□ HIV/AIDS	□ Latex Allergy /milk allergy
□ Joint Replacement	□ Cancer	= please list other ailments below
□ Liver /Kidney or lung Disease	□Pacemaker/ Defibrillator	

Please turn over

Do you smoke? _____ If so, how many per day? _____

(Women) Are you pregnant? _____ How many months? _____

DENTAL HISTORY

Are you concerned about or experiencing any of the following dental problems? (Please tick)

□ Sensitivity to hot or cold	□ Food trapping between teeth	□ Clicking/pain in the jaw joints
□ Staining of your teeth	□ Discoloured fillings	□ Roughness of existing fillings
□ Bleeding gums	□ Bad breath	□ Sensitivity when eating
□ Head/neck ache	□ Grinding/clenching of your teeth	□ Numbness
□Lumps or sores	□ Existing crowns/bridges /Dentures	□ List other concern

What treatment do you require today? _____

_____

How long since your last dental visit? _____

Does dental treatment make you nervous? □ No □ Slightly □ Moderately □Extremely

Who referred you to our Practice? _____

CONSENT FOR SERVICES

- I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated and I will assume responsibility for the fees associated with those procedures.
- I understand that the practice requires at least **24 hours notice** if I need to cancel my scheduled appointment and **MUST** be **CONFIRMED 48 HRS prior** to your appointment.
- Many emergencies are turned away in the expectation that you will arrive, if this case arises we may elect to give your appointment to others in pain/ or emergency situations, please understand
- I hereby authorise the dentist/hygienist to take x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis.
- I am aware that **payment is required** on the **day** of treatment.

Patient/Parent/Carer Signature _____ Date _____

OFFICE USE ONLY

Updated: _____ Signature: _____ Scanned: _____