LindDocs
LINDFIELD MEDICAL & DENTAL CARE

Welcome

In order to provide you treatment of a high standard, it is necessary to have the following information to assist us.
All information will be treated with complete professional confidentiality.
Please take your time to answer these questions completely as possible.

MR MRS MS MST MISS DR
SURNAME..... FIRST NAMES..... DATE OF BIRTH.....

HOME ADDRESS..... POSTCODE.....

PHONE HOME..... MOBILE..... EMAIL.....

OCCUPATION..... EMPLOYER..... PHONE WORK.....

BUSINESS ADDRESS..... POSTCODE.....

NEXT OF KIN (NOT AT YOUR ADDRESS)..... PHONE.....

ADDRESS..... POSTCODE.....

PERSON RESPONSIBLE FOR FEES.....

HEALTH FUND OR BENEFIT MEMBERSHIP.....

MEDICARE NUMBER..... EXPIRY.....REF NO.....

REFERRAL

Who may we thank for referring you to our practice? ❑ Another patient - name.....

❑ Sign outside ❑ Internet ❑ Newspaper ❑ Referral by a doctor, dentist or chemist ❑ Other.....

MEDICAL HISTORY

FAMILY HISTORY: Tick any of the following conditions from which any member of your family has suffered:

❑ Diabetes ❑ Asthma ❑ Heart Disease ❑ Blood Pressure ❑ Cancer ❑ Tuberculosis ❑ Other.....

PERSONAL HISTORY: Do you have or have you had any of the following? Please tick:

❑ AIDS/HIV	❑ Bronchitis	❑ Head injuries	❑ Pacemaker
❑ Anaemia	❑ Cancer/Tumour	❑ Heart murmur	❑ Psychiatric care
❑ Arthritis	❑ Chemotherapy	❑ Heart/vascular disease	❑ Radiation therapy
❑ Artificial knee/hip/shoulder joint	❑ Deafness	❑ Hepatitis	❑ Rheumatic fever
	❑ Diabetes	❑ Herpes	❑ Scarlet fever
❑ Artificial heart valve	❑ Digestive problems	❑ Hiatus hernia	❑ Sexually transmitted disease
❑ Asthma	❑ Earaches	❑ Immune deficiency	❑ Sinus problems
❑ Abnormal bleeding (excessive)	❑ Eating disorders	❑ Jaundice	❑ Skin trouble
	❑ Epilepsy	❑ Kidney/bladder disease	❑ Sleep apnoea
❑ Blood disorder	❑ Fainting	❑ Liver disease	❑ Stroke
❑ Blood pressure - high	❑ Frequent headaches	❑ Mouth ulcers	❑ Thyroid problems
❑ Blood pressure - low	❑ Glaucoma	❑ Nervous disorder	❑ Tuberculosis
❑ Blood transfusion	❑ Hay fever	❑ Osteoporosis	❑ Ulcers

Are you in a high risk group for Hepatitis or HIV infections? ❑ No ❑ Yes ❑ Don't know

Do you have allergies or bad reactions to anything? ❑ No ❑ Yes ❑ penicillin ❑ codeine ❑ anaesthetic ❑ latex/gloves ❑ Other.....

List any drugs, medications or supplements taken in the last 2 weeks & reasons:.....

.....

Have you been in hospital or had any operations in the last 2 years? ❑ No ❑ Yes

Are you under current medical treatment by a doctor/specialist? ❑ No ❑ Yes

Who is your usual medical doctor? .....Telephone.....

How do you rate your general health? ❑ Perfect ❑ Good ❑ Fair ❑ Poor

What is the date of your last physical examination? .....

Are you pregnant (females)? ❑ No ❑ Yes - months.....

Do you smoke? ❑ No ❑ Yes - how many per day.....

Do you drink alcohol? ❑ No ❑ Yes

Please list any other conditions that this practice should be made aware of:.....

OVER PLEASE

DENTAL HISTORY

When was your last dental visit?..... What did you have done?.....

How often do you visit a dentist?..... When did you last have dental xrays?.....

Why did you leave your last dentist?.....

WHAT IS THE PURPOSE OF TODAY'S VISIT?

❑ Check up ❑ Relief of pain ❑ Appearance ❑ Other reason.....

Are you completely happy with the general appearance of your teeth and smile? ❑ No ❑ Yes

Do you wish to improve the appearance of your teeth and smile? ❑ No ❑ Yes

WHAT PROBLEMS ARE YOU CONCERNED ABOUT? Please tick:

❑ toothache
❑ lost filling
❑ new cavity
❑ sensitive teeth to:
cold heat sweet sour pressure
❑ rapidly decaying teeth
❑ wisdom tooth problems
❑ bad breathe or taste
❑ bleeding gums
❑ loosening teeth
❑ missing teeth
❑ discoloured teeth
❑ discoloured fillings
❑ worn/broken teeth
❑ bad appearance
❑ colour/whiteness
❑ unsatisfactory denture
❑ discomfort when chewing/biting
❑ grinding/clenching of teeth day/night
❑ sounds from jaws/ears
ringing/popping/snapping/clicking
❑ jaw muscle pain
❑ snoring
❑ I don't experience any problems

Have you had any complications following extractions or other dental treatment? ❑ No ❑ Yes

Have you had any difficult tooth extractions? ❑ No ❑ Yes

Have your wisdom teeth been removed? ❑ No ❑ Yes

Have you lost any other teeth and why? ❑ No ❑ Yes

Do you want to avoid dentures? ❑ No ❑ Yes

Do you wear a night guard/occlusal splint? ❑ No ❑ Yes

Are aware of any swelling in your mouth or around your teeth? ❑ No ❑ Yes

Do your gums bleed when eating or brushing your teeth? ❑ No ❑ Yes

Does food wedge habitually between certain teeth? Does floss tear between your teeth? ❑ No ❑ Yes

Do you have a habit of thumbsucking? ❑ No ❑ Yes

Please tick if you have a habit of chewing your: ❑ Tongue ❑ Lips ❑ Fingernails ❑ Pens ❑ Other

Have you previously been referred to a: ❑ Periodontist ❑ Oral surgeon ❑ Orthodontist
❑ Endodontist ❑ Prosthodontist ❑ Pedodontist ❑ When?.....

ORAL HYGIENE

How often do you brush your teeth?..... How often do you replace your toothbrush?.....

Do you use a : ❑ Hard ❑ Medium ❑ Soft ❑ Electric ❑ Toothbrush? What brand?.....

How often do you floss?..... Do you use another cleaning aid?.....

Do you snack between meals? ❑ No ❑ Yes

Do you drink tea/coffee? How many (i) cups..... (ii) teaspoons of sugar..... ❑ No ❑ Yes

PAIN CONTROL

Does dental treatment make you nervous?

❑ No ❑ Slightly ❑ Moderately ❑ Extremely

Do you prefer local anaesthesia (an injection) for dental treatment?

❑ Yes, always ❑ If reasonably painful ❑ Only if very painful ❑ Not unless an extraction is required

Do you feel you require general anaesthesia? ❑ No ❑ Yes

Do you have a fear of dentists? ❑ No ❑ Yes Why?.....

CHECK UPS

Would you like to be placed on our continuing care program every 6 months? ❑ No ❑ Yes

How would you like to be contacted ❑ By mail - without an appointment ❑ By mail - with an appointment
❑ Telephone ❑ SMS text ❑ Make a recall appointment today

Preferred appointment time ❑ Anytime ❑ Morning ❑ Afternoon
❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday ❑ Saturday

CONSENT FOR TREAMENT

1. To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the appointment without fail.
2. I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated.
3. I will assume responsibility for all fees associated with the procedures at the time services are performed.

Signature (patient/parent/guardian)..... Date.....