

Spit Road Dental
 Dr Ian Yerbury
 16 Spit Road Mosman, NSW
 Phone: (02) 9969 4663 Fax: (02) 9969 4669

Welcome to our surgery. Please take the time to answer these questions as accurately as possible. This form will not be passed on to a third party. All information is strictly confidential and is gathered so we can provide the best treatment for you. PLEASE PRINT. Please ask to see our privacy policy if you are interested.

NAME: Mr/Mrs/Miss/Ms/Dr _____
GIVEN NAMES - UNDERLINE PREFERRED SURNAME

ADDRESS: Private: _____

_____ POST CODE: _____ PHONE (HOME): _____

OCCUPATION/SCHOOL: _____

COMPANY NAME: _____

ADDRESS: Business: _____

POSTCODE: _____ PHONE (Business): _____

MOBILE PHONE NUMBER: _____

E-MAIL ADDRESS: _____

DATE OF BIRTH: _____

I am responsible for paying the fees today.....Yes/No If No, please state who is _____

I have dental insurance.....Yes/No If Yes, which one? _____

Who referred you to this practice? _____

What is the purpose of today's visit? _____

What are your main concerns with your teeth? _____

Do you have any concern about the look of your teeth? _____

When were your teeth last checked? _____ What was the name of your previous dentist? _____

I use the following to clean my teeth (please circle):

Toothbrush, Electric Toothbrush, Dental Floss/Tape, Dental Sticks, Interproximal Brush

How do you feel about dental treatment? _____ Calm _____ Neutral _____ Tense

Have you had any problems with dental treatment in the past? _____

MEDICAL HISTORY

Doctor's Name _____ Suburb _____

Have you suffered from any of the following...(please circle Yes or No)

1. Heart/Vascular Problems..... YES / NO Details _____
2. Blood Pressure Problems.....YES / NO Details _____
3. Problems with bleeding.....YES / NO Details _____
4. Rheumatic Fever..... YES / NO Details _____
5. Diabetes.....YES / NO Details _____
6. Asthmas.....YES / NO Details _____
7. Epilepsy, Hyperthyroidism, Glaucoma.....YES / NO Details _____
8. Nervous Disorder, Hepatitis, Arthritis.....YES / NO Details _____
9. HIV / AIDS.....YES / NO Details _____
10. Kidney Disease.....YES / NO Details _____
11. Heart burn (Indigestion at night)..... YES / NO Details _____
12. Tuberculosis.....YES / NO Details _____
13. Any other major health problems?..... YES / NO Details _____
14. Have you been taking steroids in the last two years?..... YES / NO Details _____
15. Are you under current medical treatment?..... YES / NO Details _____
16. Are you on any medications or drugs?..... YES / NO Details _____
17. Have you been in hospital for anything major? Operations?..... YES / NO Details _____
18. Have you any known allergies to medicines, antiseptics etc?..... YES / NO Details _____
19. Have you had a difficult tooth extraction?.....YES / NO Details _____
20. Women if pregnant, state how many months _____

SIGNATURE: _____ DATE: _____