multicare
dental

initial patient assessment

Your care is very important to us. For us to manage your care, please answer all questions on this form

Patient information

Date ____ /____/____

Patient Name: ______________________ ☐ Male ☐ Female

Birth Date: ______________________ ☐ Married ☐ Single ☐ Child ☐ Other

Preferred Name: ______________________ Email: ______________________

Address: ______________________

Phone (Home): ____________ Phone (Work): ____________ Mobile: ____________

Employer: ______________________ Occupation: ______________________

Preferred Method Of Contact: ☐ Phone ☐ Email ☐ SMS

Insurance information

Private Health Insurance Carrier: ______________________

Membership Number: ______________________

Your reference no.: ______________________

Name of Medical Practitioner: ______________________ Contact Number: ______________________

How did you first hear of Us?

☐ Friend/relative/word-of-mouth ☐ Newspaper/magazine ☐ Internet/web site

☐ Health insurance directory ☐ Yellow Pages/phone book ☐ Dr: ____________

☐ Others ______________________

dental

massage

foot & gait

chiropractic

multicare dental

Dental History

What is you present dental concern: ____________________

When was your last dental appointment: ____________________

Do you have any dental problems now? ☐ Yes ☐ No

If yes, please describe: ____________________

a. Health

Are you concerned about or experiencing any of the following

- ☐ Sensitivity to hot, cold, sweets or pressure
- ☐ Bleeding gums, loose teeth
- ☐ Bad breath
- ☐ Gum recession
- ☐ Decay or broken teeth
- ☐ Ability to eat
- ☐ Food catching between teeth

b. Function

- ☐ Are you experiencing any of the following
- ☐ Clicking or pain in the jaw joint
- ☐ Head, neck or shoulder pains
- ☐ Grinding or clenching of your teeth
- ☐ Snoring or sleep
- ☐ apnoea
- ☐ Missing teeth

c. Cosmetics/Aesthetics

Are you dissatisfied with you teeth and their appearance. ☐ Yes ☐ No

Is there anything you would like to change about your smile ____________________

____

Are you concerned particularly about any of the following

- ☐ Crooked, misaligned, crowded teeth
- ☐ Discoloured, stained, yellow teeth
- ☐ Spaces or gaps between your teeth
- ☐ Worn teeth
- ☐ Gummy smile
- ☐ Missing teeth
- ☐ Old fillings
- ☐ Discoloured fillings
- ☐ Old veneers, crowns, bridges, dentures
- ☐ Wrinkles around you eyes, forehead, cheeks, lips or chin

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This section is essential to us in providing safe medical treatment:

Do you have any of the following? Please Tick

☐ Codeine Allergy	☐ Asthma	☐ Healing Complications	☐ Heart Murmur
☐ Penicillin Allergy	☐ Cancer	☐ Excessive Bleeding	☐ Hepatitis:Type ______
☐ Sulphur Allergy	☐ Diabetes	☐ Recurrent Headaches	☐ High Blood Pressure
☐ Other Allergy ___________	☐ Dizziness	☐ Radiation Treatment	☐ Kidney Disease
☐ Anaemia	☐ Epilepsy	☐ Respiratory Problems	☐ Liver Disease
☐ Arthritis	☐ Fainting	☐ Tuberculosis	☐ Hay Fever
☐ Artificial Joints	☐ HIV	☐ Rheumatic Fever	☐ Other ____________

Are you, or could you be pregnant? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Are you currently taking any medications or other drugs? ☐ Yes ☐ No

If yes, please state? ____

Terms & Conditions

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the dentist of any change in my health or medication.

I further consent to having my photograph taken to be placed on my personal dental file.

Preferred method of payment: ☐ Cash ☐ Cheque ☐ Credit ☐ Card Eftpos

Signature: ____ Date:________________

History Review

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