LASER DENTISTRY

Please take your time to answer these questions as completely as possible. It will assist us in our effort to provide the best dental treatment for you. Thank you

Title Mr./ Mrs./ Ms./ Miss/ Master/ Dr/ Other (Please circle)

Family Name…… First Name ……

Date of Birth: ……

Home Ph …… Mobile…… Work Ph ……

Email address: ……

Occupation …… Employer ……

Please specify preferred daytime contact: Home no. / Work no. / Mobile no. / Email

Postal Address: ……Suburb……State…… Post Code……

Residential Address: ……Suburb……State……Post Code……

When did you last complete dental treatment? …… Where……

Which Private Health Fund are you with? …… Medicare Number: ……

How did you hear about us? ……

Medical History

Have you had any serious health problems? Yes / No If yes, please specify ……

Are you allergic to any medication? Yes /No If yes, please specify……

Are you allergic to LATEX? Yes /No

Do you have any other known allergies? Yes/ No ……

Do you take any medications regularly? Yes / No

If yes, please list them……

Have you had any of the following? Please circle and specify

Heart Problems/Heart Surgery ……	Yes / No	Are you Pregnant ……	Yes / No
Vascular Disorder……	Yes / No	Diabetes (Type I/ Type II)…	Yes / No
Any Joint Replacements ……	Yes / No	Blood Pressure Problem ….	High / Low / No
Blood Disease/Bleeder……	Yes / No	Epilepsy……	Yes / No
Rheumatic Fever……	Yes / No	Asthma……	Yes / No
Hepatitis A, B or C……	Yes / No		

If 'yes' to any of the above, please give details ……

Who is your Medical Practitioner? ……Phone ……

Which dental problems do you have?

Discoloured Teeth……	Yes / No	Missing Teeth ……	Yes / No
Sensitivity to hot/cold ……	Yes / No	Pain in face or jaw……	Yes / No
Frequent headaches ……	Yes / No	Unsatisfactory denture……	Yes / No
Worn/Broken teeth ……	Yes / No	Lost/Broken fillings……	Yes / No

Reason for today's visit? ……

IT IS A POLICY OF LASER DENTISTRY THAT PAYMENT IS DUE AT THE TIME OF TREATMENT

Who is responsible for fees? Myself/ Other

If other, please specify who …… Relationship to Patient……

I agree to indemnify Laser Dentistry against all debt collection, solicitor's costs and any disembursements incurred as a result of my non payment of monies to Laser Dentistry.

Signature…… **Date**……