SALISBURY DENTAL CARE

Dr Brian Sainsbury BDS (Adel) Ph: **(08) 82582278**
Email: admin@salisburydentalcare.com.au
4 Wiltshire St SALISBURY (Corner Church St) SA 5108

Welcome to Salisbury Dental Care,

Our aim is to offer you complete, thorough and personalised dental treatment, in a pleasant and comfortable atmosphere, with special emphasis on preventive dentistry and control of pain and apprehension. A thorough examination, for your welfare, protection and comfort, requires full knowledge of your medical and dental history, and some understanding of your personal feelings.
So that we may serve you better, we ask you to complete the following questionnaire as accurately as possible. All information will be treated with the utmost confidence. Thank you.

Title……First Name……Surname……

Address……Postcode……

Male/Female Date of Birth……/……/……Health Fund Name……Number……ID No……

Medicare Card Number……ID No……Expiry Date……

Telephone: Home……Mobile……Work……

Occupation: ……Email:……

Contact Name and Phone in case of Emergency……

Name and Address of Doctor……

MEDICAL HISTORY – If you require more space, please use the back of this sheet.

Please list all current medications; **prescription and non-prescription……**

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Please list any Allergies or Adverse Drug Reactions……

Do you have, or have you ever had any of the following? - Please tick or circle relevant options

Heart Problems	Latex/Rubber Allergy	Breathing Difficulties
High blood pressure	Joint Replacement	Cancer
Asthma	Pacemaker	Stroke
Rheumatic fever	Fainting Spells/Seizures/Epilepsy	Diabetes
Hepatitis	Females, Are you pregnant?	Reflux

Do you take Blood Thinners?

Have you had Radiation Treatment?

Have you had or do you have TB?

Do you take medication for Osteoporosis?.....Please specify……

Please list any other medical conditions not listed above?.....

DENTAL HISTORY
Do you, or have you experienced any of the following?

Sensitivity to Hot/Cold	Bleeding gums
Soreness or clicking in your jaw	Clenching or grinding your teeth

Difficult extractions

What would you like the Dentist to do for you today?.....

Whom may we thank for referring you to our practice?.....Please Turn Over..

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Consent for Treatment.

Do you consent to us sending you SMS messages for appointment reminders?

1. I hereby authorise the Dentist to take x-rays, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis.

2. Upon such diagnosis, I authorise the Dentist to perform all recommended treatment mutually agreed upon by me.

3. I agree to the use of anaesthetics and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete explanation of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand that payment is due at the time of service.

5. I authorise that this data may be reviewed by team members of the Dental Practice.

The information provided is true and correct.

Date……/……/…… **Signature……**

Office Use Only: Card No_____