CARINE DENTAL SURGERY

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CARINE WA 6020
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DR JASON TANG BDSc (WA)
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DR MITRA SHABANIAN DDS(IR) PHD(SA)
DR SHEKAR SIDDAPPA BDS(IND) MDS(PROS)

MR MRS
MASTER MS

FAMILY NAME ______ GIVEN NAME ______ **D.O.B** ______

ADDRESS ______ SUBURB ______ POSTCODE ______

MOBILE ______ Email ______ HOME ______

PRIVAT HEALTH INSURANCE ______

OCCUPATION ______ EMPLOYER ______

FAMILY DOCTOR ______

RECOMMENDED BY (IF APPLICABLE) ______

Smile Assessment

So that we can provide our patients with the very best care possible, we ask that you complete this questionnaire ready to discuss your smile with your dentist.

Purpose of your visit today	

What concerns do you have about dental treatment ? Please circle				
Fear	Cost	Pain	Time	Other :

Questions	Scale of 1-10 (Please circle) 1 being you dislike strongly and 10 being you are extremely happy									
How do you currently rate your smile?	1	2	3	4	5	6	7	8	9	10
How do you feel about the colour of your teeth?	1	2	3	4	5	6	7	8	9	10
Are you experiencing any dental pain, if so how would you rate it?	1	2	3	4	5	6	7	8	9	10
How nervous are you about having dental treatments?	1	2	3	4	5	6	7	8	9	10

Would you like to change anything about the appearance of your teeth or smile, if so please circle from this list:		
	1. Fill Gaps	2. Tooth Whitening
	3. Denture	4. Implants
	5. Replace silver fillings	

MEDICAL HISTORY

HAVE YOU EVER HAD:	YES	NO	DETAILS: (*PLEASE LIST ALL MEDICATIONS)*
HEPATITIS, JAUNDICE, CONSUME EXCESSIVE ALCOHOL			
FAMILY HAD HEPATITIS			
CARDIA (HEART) COMPLAINT/VALVE PROBLEM / OPERATION			
HIGH / LOW BLOOD PRESSURE			
HISTORY OF RHEUMATIC FEVER / RHEUMATIC DISEASE			
DIABETES / FAMILY HISTORY OF DIABETES			
ASTHMA / CHEST TROUBLE / BREATHING DIFFICULTIES			

	Yes	No	
DO YOU SMOKE			HOW MANY A DAY:
KIDNEY DISEASE / UNDERGOING DIALYSIS			
LIVER DISEASE			
THYRIOD DISEASE			
OSTEOPOROSIS OR OTHER BONE DISEASES OR ARE TAKING BISPHOSPHONATES			
CHEMOTHERAPY / RADIOTHERAPY TO HEAD / NECK			
HIV / STD OR CARRY CONTAGIOUS DISEASES			
EPILEPSY / NERVE / NERVOUS SYSTEM / MENTAL HEALTH PROBLEM			
JOINT REPLACEMENTS (HIP/KNEE)			

ARE YOU CURRENTLY:	**YES**	**NO**	**GIVE DETAILS**
RECEIVING MEDICAL TREATMENT			
TAKING BLOOD THINNING MEDICATION / BLEEDING DISORDER			
ALLERGIC TO ANY MEDICATION			
FEMALE : PREGNANT / POSSIBLY PREGNANT OR BREAST FEEDING			
HAD OPERATION IN PAST 5 YRS / OTHER			

HAVE YOU EXPERIENCED PROBLEMS RELATED TO DENTAL TREATMENT

EXCESSIVE BLEEDING			
DIFFICULT EXTRACTIONS			
ALLERGY TO LOCAL ANEASTHETIC			
ANY OTHER COMPLICATIONS			

Please list in the box below any medications (including recreational, herbal, prescribed or over the counter tablets drugs/supplements etc) youare taking or have recently stopped taking :

Medications :

In signing this form I acknowledge that this represent an accurate medical history. I will advice my dental practitioner of any changes to my medical history in the future. I understand that all medical details will be treated with complete professional confidentiality.

SIGNATURE..DATE................

Changes to medical history-

SIGNATURE..DATE................

Changes to medical history-

SIGNATURE..DATE...............

Changes to medical history-

SIGNATURE..DATE................