DR IAN E. YERBURY (BDS)

Dental Surgeon

Spit Road Dental, 16 Spit Road MOSMAN 2088

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 interested.

NAME:Mr/Mrs/Miss/Ms/Dr____

GIVEN NAMES - UNDERLINE PREFERRED SURNAME

ADDRESS____

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?____________________________

How did you find our practice? (please circle) Walked past , drove past, Google, Other online __________

Yellow Pages , Referral from family or friend (name)______________ Find a Dentist,,,,,,other__________

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? Please circle Calm Neutral Tense

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

Do you normally have a local anaesthetic with fillings?____________________________

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. Any other major health problems?.. YES / NO Details__________________

11.Have you been taking steroids in the last two years?..........................YES / NO Details__________________

12. Are you under current medical treatment?... .YES / NO Details__________________

13. Are you on any medications or drugs?..YES / NO Details__________________

14. Have you been in hospital for anything major? Operations?........ .YES / NO Details__________________

15. Have you any known allergies to medicines, antiseptics etc?....... ..YES / NO Details__________________

16. Have you had a difficult tooth extraction?..YES / NO Details__________________

17. Women, if pregnant, state how many months____________________________________

SIGNATURE:____DATE:____________________