Welcome to our Practice! Please answer the following questions as accurately as possible to assist us in our effort to provide the best possible dental care for you. All information provided will be treated with complete professional confidentiality.

GRIFFITH STREET FAMILY DENTAL

Your Local Smile Professionals

Dr, Mr, Mrs, Ms, Miss, Master

Surname.....First Name.....Date of Birth.....

Address.....

Telephone: Home..... Mobile: ..... Work: .....

Email:.....

Required for your records. We promise not to spam you or share your information with 3rd parties. We have security to help prevent data breaches. If you do not want us to contact you via email you can check this box ☐

HOW DID YOU HEAR ABOUT US? PLEASE TICK

Health Fund		Shop A Docket		Walk By		Social Media	
Local Search / Local Directories		Our Webpage		Google		Person	

Please name so we can thank them

PAYMENT OF FEES IS REQUIRED AT TIME OF TREATMENT

Do you have PRIVATE HEALTH DENTAL insurance? _____ Which Fund? _____

CONFIDENTIAL DENTAL HISTORY

Do you have an immediate dental problem? Please describe_____

How long since your last dental visit? _____ Were X Rays taken? YES_____NO_____

Are any of your teeth sensitive to (please circle): HOT COLD SWEETS CHEWING

Do you suffer from sores, ulcers or blisters in your mouth? YES_____

NO_____

Do you ever clench or grind you teeth? YES_____ NO_____

Do you smoke? YES_____ NO_____ Do you want to Quit? YES_____ NO_____

Are you interested in Cosmetic Dentistry? YES_____NO_____

Would you like to keep all your teeth for life? YES_____NO_____

How nervous are you about having Dental Treatment (Please Circle)

Not Nervous 1 2 3 4 5 6 7 8 9 10 Very Nervous

Have you ever had an upsetting dental experience? NO____YES_____

_____

CONFIDENTIAL MEDICAL HISTORY

Are you presently suffering from any medical condition or illness? If yes, please give details:

_____

Name of Doctor: _____ Doctor Phone No_____

Have you undergone any surgical procedures during the past 5 years? If yes, please give details:

_____

Date of Procedure _____

Do you have, or have you had, any of the following conditions or treatments? Please tick either YES or NO

CONDITION	YES	NO	CONDITION	YES	NO
Heart Issues (Attack)			High Blood Pressure		
Congenital Heart Disease			Low Blood Pressure		
Heart Valve Disease / Artificial Valve			Hepatitis A		
Irregular Heart Beat / Heart Murmur			Hepatitis B		
Heart Pacemaker			Hepatitis C		
Rheumatic Fever			Thyroid Condition		
Kidney Disease			Arthritis		
Renal Dialysis			Epilepsy		
Liver Disease			Osteoporosis		
Organ Transplant			Diabetes **Type 1 / Type 2** (please circle)		
Joint Replacement			Sinus		
Asthma			Radiation Therapy		
Lung Disease			Chemotherapy		
Emphysema / COPD			Blood Transfusion		
Tuberculosis			HIV / AIDS		
Blood Thinners (Anti-Coagulants)			Stroke		

Do you smoke? **Yes / No**

Do you have any allergies or reactions to ANY medications? **Yes / No**

What are they? .....Reaction .....

Do you have any allergies to materials such as Latex or Rubber? **Yes / No**

What are they? .....Reaction .....

Are you on any Medications? If yes, please give a detailed list (Including Vitamins and Over the Counter Medications)	
Are you pregnant and/or Breastfeeding?	**Yes / No**
If pregnant, how many weeks?	

SIGNATURE_____**DATE**_____

All personal information collected by GSFD is handled in accordance with our privacy policy, available on the ADA website. By signing this form you hereby agree and acknowledge that: (1) You have accurately completed this form to the best of your knowledge (2)You are responsible for payment of all services rendered, and on behalf of your dependents; (3) Payment in full is due at time of service.