TLC dentistry
always caring. always here.

Personal Details:

Title:_____ Full Name:_____ Preferred Name:_____

DOB:___/___/___ Address:_____

Mobile Phone:_____ Home Phone:_____

Email Address:_____ Occupation:_____

Whom may we thank for referring you?

☐ Google ☐ Facebook ☐ Signage ☐ TV Ad ☐ WOM

Please rate your dental phobia on a scale. None 1 2 3 4 5 6 7 8 9 10 High

Would you like to receive our latest news via Email? Yes / No

Would you allow photos to be taken for diagnostic purposes and records keeping? Yes / No

What prompted today's visit? _____

_____

Emergency Contact and Medical History:

Emergency Contact: _____ Phone:_____

Are you in a health fund? If so, which one? _____

Do you have a GP? If so, which medical practice do you go to? _____

Do you weigh more than 140 kg? Yes / No (For treatment safety only.)

Please tick if you have or had any of the following:

Heart Murmur	YES / NO	High Blood Pressure	YES / NO
Heart Surgery	YES / NO	Rheumatic fever	YES / NO
Diabetes	YES / NO	Asthma	YES / NO
Epilepsy / Seizures	YES / NO	Fainting /Dizzy Spells	YES / NO
Hepatitis A, B or C	YES / NO	HIV/ AIDS	YES / NO
Bleeding Disorder	YES / NO	Thyroid Problem	YES / NO
Kidney Trouble	YES / NO	Radiation/Chemo	YES / NO
Depression	YES / NO	Anxiety	YES / NO
Liver Disease	YES / NO	Are you a smoker?	YES /NO
Osteoporosis	YES / NO	If yes, how many a day?	_____

Please list any medication that you are allergic to.

_____

Please list any medication you are taking at the moment, including any over the counter medication.

_____

_____

FOR WOMEN ONLY: Are you pregnant? Yes / No How many months? ____ Breastfeeding? Yes / No

TLC dentistry
always caring. always here.

General Health Questions:

Do you have frequent headaches or migraines?	YES / NO
Have you ever suffered a severe blow to the head?	YES / NO
Do you have neck pain or stiff neck muscles?	YES / NO
Do you have lower back pain?	YES / NO
Do you have jaw pain?	YES / NO
Do you hear clicking or popping from your jaw joint?	YES / NO
Do you have difficulty opening your mouth wide?	YES / NO
Does your jaw ever get locked?	YES / NO
Do you suffer from ringing in the ears?	YES / NO
Have you had orthodontic treatment?	YES / NO
Were teeth removed for orthodontic treatment?	YES / NO
Do you snore?	YES / NO
Do you fall asleep easily?	YES / NO
Do you stay asleep at night?	YES / NO
Do you wake up in the morning feeling refreshed?	YES / NO
Do you suffer from sleep apnea?	YES / NO
Do you have difficulty wearing your CPAP machine?	YES / NO

Thank you for your time filling out this medical questionnaire. Our principal dentist Dr Linda Gao has special interest in treating chronic pain, snoring and sleep apnea. So if you ticked yes to the above questions, we would love to have a chat with you and explain how we can help you reduce pain and sleep better.

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in completion of this form. I understand that it is my responsibility to inform the doctor if I, or my minor child, ever have a change in health.

Signature:_____ Date:_____