ANOKHI DENTAL

Welcome to Anokhi Dental.

So that we may provide you with the best possible care, please take the time to complete this form. All information provided is completely confidential.

Title: _____ First Name: _____ Surname: _____ Date of Birth _____ /_____ /_____

Address: _____ Suburb: _____ Postcode: _____

Phone #: H: _____ W: _____ M: _____

Email: _____

Would you like to receive our e-newsletters? Y N Occupation: _____

Next of Kin: _____ Phone number: _____

How did you hear about Anokhi Dental?: _____

Medical History

Have you been under the care of a medical doctor or practitioner during the past two years? Y N

If yes, for what: _____

Doctor/Practitioner name: _____ Phone: _____

Have you been a patient in hospital in the past five years? Y N

Have you taken any medications or drugs in the past two years? Y N

Are you taking any medications or drugs now? Y N

Have you ever taken any bisphosphonate medications? Y N

Are you taking vitamins or supplements now? Y N

Please provide names and dosages if you have answered yes to any of the above: _____

_____

Are you allergic to any medications, including penicillin? Y N _____

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Please indicate which of the following you have (or have had), and provide details:

Heart Disease (angina, attack, dysrhythmia)	Y	N
Congenital heart disease (heart murmur, prolapsed mitral valve)	Y	N
Rheumatic Fever/ Endocarditis)	Y	N
Heart Surgery	Y	N
Artificial heart valve or pacemaker	Y	N
Stroke	Y	N
High/Low Blood Pressure	Y	N
Bleeding abnormalities (warfarin therapy, haemophilia)	Y	N
Respiratory Disease (asthma, bronchitis, emphysema)	Y	N
Diabetes	Y	N
Thyroid Disease	Y	N
Kidney/Urogenital Disease	Y	N
Liver Disease (jaundice, cirrhosis)	Y	N
Digestive Disorders (reflux, leaky gut, Candida)	Y	N
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Osteoporosis	Y	N
Arthritis/ Artificial Joints (hip, knee etc)	Y	N
Malignancy	Y	N
Chemotherapy	Y	N
Radiotherapy	Y	N
Surgery	Y	N
Neurological Disorders (anxiety, depression, epilepsy, dementia,)	Y	N
Allergies (hay fever, latex)	Y	N
Chronic Fatigue Syndrome	Y	N
HIV/AIDS	Y	N
Hepatitis	Y	N
Tuberculosis	Y	N
Do you smoke?	Y	N
Do you consume alcohol?	Y	N

Do you:

Snore	Y	N
Have pauses in breathing/gasping for air while sleeping	Y	N
Experience excessive daytime tiredness	Y	N
Suffer from irritability, depression, mood swings	Y	N
Frequently wake up with a headache	Y	N
Experience unexpected weight gain	Y	N
Have you ever had a sleep study?	Y	N

Ladies, are you:

Taking a Birth Control Pill	Y	N
Planning pregnancy	Y	N
Pregnant	Y	N
Breastfeeding	Y	N
Undergoing IVF	Y	N

Please provide more information if you have ticked "Yes" to any of the above or if you have, or had any disease, condition or problem not listed:

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Dental History

What is the reason for your visit? _____

When did you last visit a dentist? _____

How often do you have dental examinations? _____

Last dental cleaning? _____ Last full mouth x-rays? _____

How often do you brush your teeth? _____ How often do you floss? _____

What oral care products (toothpaste, mouthwash etc.) do you use? _____

Do you have any dental problems now? Y N

If yes, please describe: _____

_____

_____

Do your gums bleed or hurt?	Y N	Have you ever experienced dental infections?	Y N
Do you experience bad breath or a bad taste in your mouth?	Y N	Have you had dental decay or fillings	Y N
Have you noticed any loose teeth or change in your bite?	Y N	Have you had any crowns or bridges placed in your mouth?	Y N
Does food tend to get caught between your teeth	Y N	Have you ever had root canal treatment?	Y N
Do you experience mouth ulcers, cold sores or any other oral lesions?	Y N	Do you have any dental implants?	Y N

Are any of your teeth sensitive to:

Hot or Cold	Y N	Are you missing teeth?	Y N
Sweet	Y N	Do you wear dentures?	Y N
Biting or Chewing	Y N	Do you ever clench or grind your teeth while awake or asleep?	Y N
Do you experience difficulty chewing?	Y N		

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Dental History (cont...)

Have you ever had:

Your teeth ground or the bite adjusted?	Y N	A bite plate or mouth guard	Y N

Do you experience:

Clicking or popping of the jaw?	Y N	Are you satisfied with the appearance of your teeth?	Y N
Headaches, neck or shoulder tension?	Y N	Do you feel nervous about having dental treatment?	Y N
Tired jaws, especially in the morning?	Y N	Have you ever had an upsetting dental experience?	Y N
Are you sensitive to anaesthetics and/or dental materials?	Y N		

If you have answered yes to any of the above, please provide more information below

I understand that I must provide 24 hours of notice for rescheduling or cancelling an appointment or I will be charged a $100 fee. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all of the questions to the best of my knowledge. I will notify the dentist of any change in my health or medication.

Patient/Guardian Signature: _____ Date: _____

Thank you.

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