centennial smiles
personalised care

Welcome to Centennial Smiles. Please answer the following questions as completely as possible. It will greatly assist us in our efforts to provide the best dental treatment for you, as well as ensuring our treatment is compatible with your present state of health.

Personal Details

Surname_____ First Name_____ Preferred Name_____

Miss/Ms/Mrs/Mr/Dr

Date of birth_____ Home Address_____

Home Phone_____ Work Phone_____ Mobile Phone_____

Email Address

Emergency Contact (please provide name and phone number):_____

If under 18 years old – parent's names/address/phone details:_____

Dental insurance □Yes □No Dental insurance company:_____

Is another member of your family a patient at our office? □Yes □No_____

Whom may we thank for referring you to our office?_____

If not personally referred, how did you find us?_____

Why are you seeking dental care today? _____

Medical History - Have you ever had any of the following? Please tick if yes.

◻ Penicillin allergy	◻ Arthritis	◻ Heart murmur	◻ Kidney disease	◻ Radiation therapy
◻ Other drug allergies	◻ High blood pressure	◻ Rheumatic fever	◻ HIV	◻ Epilepsy
◻ Latex allergy	◻ Heart disease	◻ Stroke	◻ Liver disease	
◻ Artificial joint	◻ Pacemaker	◻ Diabetes	◻ Cancer	

◻ Women, are you pregnant? If yes, now many months?_____

Are you currently taking any medications? ◻ Yes ◻ No If yes, please list:_____

_____

Dental History

Last dental visit? ◻ Less than 6 months ◻ Less than 2 years ◻ More than 2 years

What was done at your last dental visit?_____

Previous dental radiographs (dental xrays) ◻ Less than 1 year ◻ More than 1 year

Why did you leave your last dentist?_____

Have you had any of the following? Please tick if yes.

◻ Have you ever had orthodontic treatment?	◻ Do your jaw joints click or hurt?
◻ Do you feel you grind or clench your teeth?	◻ Do you smoke?
◻ Do you suffer from sleep apnoea?	◻ Do you wear a night guard?
◻ Do you have occasional bad breath?	◻ Do your gums bleed when you brush your teeth?
◻ Have you ever had gum disease?	◻ Are your teeth sensitive to hot/cold food and drinks?
◻ Does floss tear between your teeth?	◻ Does food get jammed between your teeth?
◻ Do any teeth hurt when you bite hard?	

Signature:_____ Date:_____

Thank you for your time in completing this form.