Cairns Dental Boutique
the art of dentistry

1 Pyne Street Edge Hill Cairns 4870
Ph: 07 4032 3236 Fax: 07 4053 7021
Mobile: 0401 768 644
info@cairnsdentalboutique.com.au
www.cairnsdentalboutique.com.au
ABN : 60151611326, ACN: 151611326

It is important to know details about your medical and dental history as these could affect the success of your dental treatment and how we can provide this treatment safely for you. The information you provide in this form will remain private and confidential.

Title:_____ First Name:_____ Last Name_____ Preferred Name: _____

D.O.B.: ____/____/_____ Occupation: _____

Address: _____ Post Code: _____

Home phone: _____ Mobile: _____ Email: _____

Health Fund Name: _____ Smile Member? YES / NO if yes, please note smile member no #_____

How did you discover the practice? _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

PLEASE CIRCLE OR TICK, IF YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS:

Gastric Ulcer	Rheumatic Fever	Thyroid Disorder
Asthma	Osteoporosis	Steroid Therapy
Bronchitis	Chemotherapy/ Radiation Therapy	Diabetes
Hepatitis A/B/C	Psychiatric Condition	High/Low Blood Pressure
HIV	Reflux	Heart Disease
Epilepsy	Heart Valve Replacement/Pacemaker	Bleeding Disorder
Artificial Joints	Anxiety/Depression	

Any other conditions: _____

Do you Smoke? YES / NO

Are you pregnant? YES / NO Due Date:

Do you require antibiotic cover, for your heart, before dental treatment? YES / NO

Do you have any allergies? Details: _____

Please list any medications you are currently taking (Prescription, over the counter or herbal): _____

_____

DENTAL HISTORY:

Date of your last dental visit? (If not previously with Cairns Dental Boutique) _____

Reason for that visit? _____

Have you had complications following previous dental treatment? (if yes, please explain) _____

_____

Have you ever had any of the following?

Occasional Bad Breath	Bleeding Gums when brushing	Sensitivity to hot or cold
Treatment for Gum Disease	Root Canal Treatment	Crown Treatment
Dental Implants	Dental Trauma	

Difficulty achieving numbness or an adverse reaction to anaesthetic? (please explain) _____

_____

Do you use: Manual Toothbrush Electric Toothbrush Floss Piksters or another flossing aid

How often do you clean your teeth daily: Once Daily Twice Daily Other:_____

Practice policy is that payment of account is required in full on the day of treatment, we ask if you have any concerns with making payment at your appointment that you speak to our staff prior to treatment. Failure to make payment for our services will result in debt collection action and any costs associated with debt recovery will be passed on to you.

As your Oral Health Providers, in order to assist in maintaining optimal oral health of our patients, when you attend for routine check-up and clean services you will automatically be re-booked for an appointment, at the recommended 6monthly intervals.

For all bookings made, we will communicate with details of the appointment and it is requested that you respond to confirmation, or where required request appropriate appointment changes.

Additionally, we also send our patients regular marketing relating to dental healthcare and our practice promotions, please inform our Reception should you not wish to receive this correspondence.

By signing below, you confirm your knowledge and acceptance to the above-mentioned practice policies.

Patient's/Guardian's Signature: _____ Date: _____