T.L.C. dENTISTS
ALWAYS RELIABLE

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Welcome !
We thank you for placing your trust in us. At TLC dentists, it is a great privilege to look after those people who place a high priority in maintaining or restoring their bite and smile.

Our philosophy:
TLC dentistry is focused on the *Conservation of Teeth* whether it is using fluoride releasing fillings, non-extraction braces or biocompatible implants, our aim is to inform you about the *Reliable* repair, reinforcement or replication of your current teeth.

Please fill in this form so that we can take the best care of you. Information collected is used only for purposes as per the Privacy Act of NSW. Your image may be recorded for security purposes.

Name: _____ _____ Birthdate: _____/_____/_____

Address: _____ _____ _____ Postcode: _____
(number) *(street)* *(suburb)*

Phone numbers: Home:_____ Work: _____ Mobile: _____
How did you choose this practice ?
*(Who recommended us to you ?)*_____ E-Mail: _____

Occupation: _____ Dental Health Fund: _____

Dental Health Fund Card Number_____Person number_____ Expiry Date_____
(*Please note: Fees are payable at each appointment – no accounts are to be given.*)

Dental: (*please circle your answers)*

Are any of your teeth sensitive to: ❍*heat* ❍*cold* ❍*sweet* ❍*biting*

Do you have:

Bleeding gums ?	❍*yes*	❍*no*	Sore teeth ?	❍*yes*	❍*no*
Bad odour/ taste in your mouth	❍*yes*	❍*no*	Loose teeth ?	❍*yes*	❍ *no*
Sore gums ?	❍*yes*	❍*no*	Sharp teeth ?	❍*yes*	❍*no*
Dark or stained teeth ?	❍*yes*	❍*no*	Crooked teeth ?	❍*yes*	❍*no*
Swelling in your mouth ?	❍*yes*	❍*no*	Do you wear a denture ?	❍*yes*	❍*no*

Do you like us explaining your dental treatment ? ❍*yes* ❍*no*
Does having dental treatment worry you ? …… ❍*yes* ❍*no* If so, why ? _____

When did you last see a dentist ? _____

Why did you stop seeing your last dentist ? _____

What is your present dental problem ? _____

Medical:

Are you seeing a doctor or been to hospital recently ? ❍*yes* ❍*no* *reason*_____

Who is your medical doctor ? Dr_____ Phone: _____

Ladies: Are you pregnant ? ❍*yes* ❍*no* *When are you due ?* _____

Are you taking any prescribed medication ? *Please specify:* _____
(eg. High Blood Pressure, Aspirin, Warfarin, Corticosteroids)

Have you ever had an allergic reaction ? ❍*yes* ❍*no* *Please specify: (eg. Penicillin)*_____

Have you ever had :

❍Diabetes	❍Respiratory Disease *(eg. Asthma)*	❍High Blood Pressure
❍Epilepsy	❍Any Heart Condition	❍Bisphophonates for Bone Problems
❍Rheumatic Fever	❍Hepatitis A, B, or C or HIV	❍Prolonged bleeding
❍Joint Replacement	Anything else that we should know ?_____	

Signature:

date: _____/_____/_____ Thank you !

_____