Peninsula Dental

*Where your smile matters*

**We would like to welcome you to our practice**. To assist us in providing you with the best possible treatment and standard of care, we ask that you complete this confidential medical history questionnaire.

**Title:** **Mr** **Mrs** **Miss** **Ms** **Master** **Dr**

**Surname:** _____ **First Name:** _____

**Date of birth:** _____ **Age:** _____ **Sex:** **Male** **Female**

**Street Address:** _____**Suburb**_____ **Postcode** _____

**Phone contact: Home:** _____ **Work:** _____ **Mobile:** _____

**Occupation:** _____ **Email Address:** _____

**Emergency contact Name:** _____**Phone:** _____

**Name of school attending or any teaching Institution:** _____

**How did you hear about us:** ☐ **Recommendation from existing patient: (Name)** _____
☐ **Yellow pages** ☐ **Internet search (Google)** ☐ **Saw sign** ☐ **Other: (Name)** _____

**Reason for Attending for This Appointment:** _____

**Are You in Pain:** _____

**Are Your Teeth Sensitive to Hot, Cold or Sweet Foods?** _____
**Does Your Gum Bleed?** _____
**Would You Like Your Teeth Whiter?** _____

## DENTAL HISTORY

**Is There Any Thing Else We Should Know About Your Teeth or Oral Health?** _____

_____

_____

**Please turn over**