Dental Serenity
Your Health Your Smile

New patient interview form

Read our Privacy Policy

Prof Dr Mr Mrs Ms Miss Master

Health Insurer _____

Full name _____ Date of birth _____

Address _____

Home phone _____ Work phone _____

Mobile _____ Email _____

Occupation _____ Employer _____

Emergency contact name _____ Number _____

How were you reffered here? _____

When was last visit to a dentist? _____ Why? _____

Main concern for visit today _____

Are your teeth sensitive to: Heat Cold Sweet Biting pressure

Do your gums bleed when brushing or flossing? _____

Have you had any complications during or following dental treatment? _____

Have you had prolonged bleeding after tooth removal or dental surgery? _____

Do you grind your teeth or clench your jaw? _____

Is there anything you would like to change about your teeth or their appearance? _____

Who is your General Practitioner? _____ Number _____

Are you currently being treated for a medical condition? _____

Are you taking any medications or supplements at present, both prescribed and over the counter? _____

Do you currently have, or have you ever had any of the following medical conditions?

Steroids	Stomach or digestive problems (reflux)	Excessive Bleeding	Rheumatic Fever
Leukemia, cancer	Hepatitis, Liver Disease	Epilepsy	Nervous Condition
Anaemia or Blood disorder	Asthma	Diabetes	Heart Valve disorder
Stroke	Radiation and Chemotherapy	Kidney disease	Heart complaint/surgery
Eating disorder	Tuberculosis	Thyroid disease	Heart murmur
High/low blood pressure	Cardiac pacemaker	Contact with HIV/AIDS virus	Prosthetic implant
Bonchitis	Emphysema or other lung disease	Transported organ or bone marrow	

Do you have allergies? Please list: _____

Do you smoke? _____

For women, are you pregnant or undergoing fertility treatment? _____

Your Signature _____ Date _____

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