Welcome

Thank you for choosing **AYAR DENTAL** as your dental healthcare team! We promise to always provide you with the best possible dental care for you and your family. In order to meet your dental healthcare needs, please fill out this form completely. If you have any questions, please ask us – we're happy to help!

Patient Information

Mr Mrs Ms Miss Mast

Name _____ Date of Birth _____

Address _____ Post Code _____

Home Phone _____ Work Phone _____

Mobile _____ Email _____

Emergency Contact Name _____ Phone _____

How did you hear about us? _____

Occupation _____ Dental Insurance _____

Dental History

Name of Last Dentist _____ Last Visit? _____

Reason for today's visit? _____

Have you ever had a serious problem from a previous dental treatment? ☐ Yes ☐ NO

If yes, please explain _____

How often do you brush? _____ How often do you floss? _____

How often do you get cleanings? _____

Please mark the ones that apply to you:

- ☐ Hesitant to come to the dentist
- ☐ Snore or have trouble sleeping
- ☐ Gums bleed during brushing and flossing
- ☐ Food frequently gets stuck in teeth
- ☐ Have fillings you don't like
- ☐ Would like whiter teeth
- ☐ Have a bad odor or taste in the mouth
- ☐ Would like straighter teeth
- ☐ Have missing teeth you would like to replace
- ☐ Have loose dentures or partial

Is there anything you don't like about your smile? _____

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Facial Cosmetic History

Have you had Facial Injectables? ☐ Yes ☐ No

If yes, when did you have the Facial Injectables? _____

Medical History

Who is your medical doctor?_____

Are you taking any medications or supplements at present, both prescribed or over the counter? (Please list)

_____

_____

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

- º Steroid therapy
- º Epilepsy
- º Diabetes
- º Stroke
- º Kidney disease
- º Eating disorder
- º Leukaemia, cancer
- º Tuberculosis
- º Heart murmur
- º Transplanted organ or bone marrow
- º Excess bleeding
- º Contact with HIV/AIDS virus
- º Prosthetic implant eg. prosthetic hip or knee
- º Rheumatic fever
- º Asthma
- º Heart valve disorder
- º Radiation or chemotherapy
- º Heart complaint or heart surgery
- º Stomach or digestive condition e.g. reflux
- º Nervous condition
- º Thyroid disease
- º High or low blood pressure
- º Cardiac pacemaker
- º Hepatitis or liver disease
- º Anaemia or blood disorder
- º Bronchitis, emphysema or other lung disease

Other

_____

_____

Please list all known allergies (eg penicillin, latex) _____

_____

Do you smoke? _____ How many_____ /day

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

Your signature: _____ Date: _____