spring dental
a fresh approach to dentistry

Dr Arun Mohan B.D.S. (Syd Uni)
Dr Ivan Friedlander B.D.S. (Rand)
53 Wairoa Ave North Bondi NSW 2026
T 02 9130 3212 F 02 9365 7407
E northbondi@springdental.com.au
www.springdental.com.au

Personal Details

Name____Date of Birth____/____/____________.

Home Address____Postcode_____________________.

Postal Address____Postcode_____________________.

Identification Provided ☐ Drivers Licence ☐ Passport ☐ RTA Photo Card ☐ Medicare Card

Occupation____________________________Email address_______________________________________.

Home Phone_______________Work Phone_______________Mobile________________________________.

What is your preference for communication from our practice? (Please number 1-5)

☐ Home ☐ Work Phone ☐ Mobile ☐ Sms ☐ Email

Who recommended you to us?____.

Have you heard about us anywhere else?_____If yes, where?___________________________________.

Are you covered by a private health fund for dental treatment? ☐ Yes ☐ No

If yes, name of fund?____.

Will you be claiming Worker's Compensation or Third Party Insurance? ☐ Yes ☐ No

If yes, name of Insurance Company______________________________Claim Number________________.

Who is responsible for the payment of your accounts? If not self, please provide name, address and phone number of responsible person/s ____.

____.

Dental History

What is the reason for your visit today?____.

Date of last dentist visit____/____/______What was done at your last dental visit?__________________.

.___________________________________Did this include… ☐ dental cleaning? ☐ full mouth x-rays?

Previous Dentist's name_____________________________________Telephone_____________________.

Address____State_________Postcode___________.

How often do you have dental examinations?____.

How often do you brush your teeth?_______________________How often do you floss?______________.

What other aids do you use? (Interplak, toothpick etc.)____.

Do you have any dental problems now?____.

If yes, please describe____.

Do you feel nervous about dental treatment, if yes what is your biggest concern?____________________.

____.

spring dental
a fresh approach to dentistry

Dr Arun Mohan B.D.S. (Syd Uni)
Dr Ivan Friedlander B.D.S. (Rand)
53 Wairoa Ave North Bondi NSW 2026
T 02 9130 3212 F 02 9365 7407
E northbondi@springdental.com.au
www.springdental.com.au

TEETH

Are any of your teeth sensitive to…	Yes	No
Hot or cold?	☐	☐
Sweets?	☐	☐
Biting or chewing?	☐	☐

GUMS

	Yes	No
Do your gums bleed or hurt?	☐	☐
Have you notice any mouth odours or bad tastes?	☐	☐
Have your parents experienced gum disease?	☐	☐
Have you noticed any loose teeth or change in your bite?	☐	☐
Does food tend to become caught between your teeth? If yes where?	☐	☐

.____.

HAVE YOU EXPERIENCED…

	Yes	No
Clicking or popping jaw?	☐	☐
Pain in (joint, ear, or side of face)?	☐	☐
Difficulty in chewing on either side of the mouth?	☐	☐
Difficulty opening or closing mouth?	☐	☐
Headaches, sore muscles, temples cheeks?	☐	☐

PROCEDURES

Have you ever had…	Yes	No
Dental implants?	☐	☐
Orthodontic treatment?	☐	☐
Oral surgery?	☐	☐
Periodontal or gum treatment?	☐	☐
Your teeth ground or bite adjusted?	☐	☐
A plate for grinding?	☐	☐
A mouth guard?	☐	☐
A retainer after orthodontics?	☐	☐
Problems with dental infections? If yes, please describe, including cause:	☐	☐

.____.

	Yes	No
A serious injury to your mouth or head?	☐	☐

COSMETICS

	Yes	No
Are you satisfied with the appearance of your teeth? If not, why?___________.	☐	☐

.____.

	Yes	No
Would you like whiter teeth?	☐	☐

DO YOU

	Yes	No
Snore?	☐	☐
Smoke?	☐	☐
Clench or grind your teeth while awake or asleep?	☐	☐

spring dental
a fresh approach to dentistry

Dr Arun Mohan B.D.S. (Syd Uni)
Dr Ivan Friedlander B.D.S. (Rand)
53 Wairoa Ave North Bondi NSW 2026
T 02 9130 3212 F 02 9365 7407
E northbondi@springdental.com.au
www.springdental.com.au

Medical History

Have you been under the care of a medical doctor during the last two years? Yes ☐ No ☐

If yes, for what?____.

Have you taken any regular medication or drugs during the last two years? Yes ☐ No ☐

Are you taking any medication, drugs or pills now? Yes ☐ No ☐

If yes please list:

Date recorded	Drug	Dosage	Condition

Are you taking any medication for osteoporosis? Yes ☐ No ☐ If yes, what? ____________________.

Are you taking any blood thinners, for example Aspirin or Warfarin? Yes ☐ No ☐

Are you aware of having an allergic (or adverse) reaction to any medication or substance?

Yes ☐ No ☐ If yes, please list:____.

.____.

Have you been in hospital during the last 5 years? Yes ☐ No ☐ If yes, for what?______________.

.____.

Have you ever been treated for the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Heart disease/attack	☐	☐	Stomach ulcers	☐	☐	Diet(special restricted)
☐	☐	Chest pain	☐	☐	Reflux	☐	☐	Nervous/Anxious
☐	☐	Congenital heart disease	☐	☐	Diabetes	☐	☐	Fainting or dizzy spells
☐	☐	Heart murmur	☐	☐	Thyroid problems	☐	☐	Neurological disorders
☐	☐	High blood pressure	☐	☐	Tuberculosis	☐	☐	Epilepsy or Seizures
☐	☐	Mitral valve prolapse	☐	☐	Asthma	☐	☐	Kidney trouble

spring dental
a fresh approach to dentistry

Dr Arun Mohan B.D.S. (Syd Uni)
Dr Ivan Friedlander B.D.S. (Rand)
53 Wairoa Ave North Bondi NSW 2026
T 02 9130 3212 F 02 9365 7407
E northbondi@springdental.com.au
www.springdental.com.au

Yes	No		Yes	No		Yes	No	
☐	☐	Artificial heart valve	☐	☐	Latex sensitivity	☐	☐	Liver Disease
☐	☐	Heart pacemaker	☐	☐	Allergies or Hives	☐	☐	Bruises easily
☐	☐	Rheumatic fever	☐	☐	Sinus troubles	☐	☐	Blood Transfusion
☐	☐	Arthritis/rheumatism	☐	☐	Radiation therapy	☐	☐	Haemophilia
☐	☐	Cortisone medicine	☐	☐	Chemotherapy	☐	☐	Tumours
☐	☐	Stroke	☐	☐	Hepatitis	☐	☐	Osteoporosis
☐	☐	Psychiatric / psychological care	☐	☐	Artificial joints (hip, knee,etc)	☐	☐	Snoring or Sleep Apnoea
☐	☐	A.I.D.S/H.I.V positive						

Do you have or have had any disease, condition or problems not listed? Yes ☐ No ☐

If yes, please list:____.

For Women, are you pregnant? Yes ☐ Weeks? ☐ No ☐ Nursing? Yes ☐ No ☐

Do you think you may be pregnant? Yes ☐ No ☐ Taking birth control pills? Yes ☐ No ☐

I understand the information within these pages is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you .I will notify the dentist of any change in my health or medication.

Patient signature____Date_________________________.

Guardian/Attendee/Carer ____________________________________Date_________________________.

A parent or guardian signing on behalf of a child or someone in your care is ultimately responsible for the payment of dental treatment provided by us.

From time to time our dentists participate in educational lectures or research, which sometimes requires treatment records of their patients. All records such as x-rays and photos that are used are done so anonymously. If the need arises would you allow your treatment records to be utitised for this purpose? Yes ☐ No ☐ (please tick)