Integrated Dental Health

A Holistic Approach

Please feel free to ask reception if you have any questions about this form.
If you are under 18, please ensure a parent or guardian completes this form on your behalf.

Contact Details

Title:	Full name	Date of Birth:
Occupation:		
Next of Kin:		Contact number of Kin:
Relationship to Kin:		
Address:		
Suburb:		Postcode:
Home phone:		Mobile:
Email:		
How do you prefer your appointment reminders to be sent?		□ SMS □ Email
If the payment of your account involves another person, would you like us to discuss your treatment with them? _____		

Medical History

□ Rheumatic fever	□ Kidney problems	□ Anaemia / blood disorders
□ Diabetes	□ Liver problems	□ Sleep apnea/breathing issues
□ Low/high blood pressure	□ ADHD/sensory issues	□ Autoimmune disease
□ Malaria	□ Gastric reflux	□ Creutzfeldt Jacob disease
□ Epilepsy	□ Heart conditions	□ Artificial joint (in last 2 years)
□ Anxiety/depression	□ Asthma	□ Are you pregnant ?
□ Cancers	□ Motor neuron disorders	
□ Other (please list)		
Please list any medications you're taking:		
Please list any sensitivies and/or allergies:		
Have you ever had an unfavourable reaction to local or general anaesthetics?	□ No	□ Yes

Dental History

Can you please let us know what your main concerns are short term, long term, and, in particular today are ?

Dental phobia/history of bad dental experience	Y/N	Do you suffer from headaches?	Y/N
Does your jaw click or hurt?	Y/N	Do you experience sensitivity with hot or cold?	Y/N
When was your last dental check up?		Do your teeth hurt when you bite hard?	Y/N
Do your gums bleed ?	Y/N	Do you feel you grind or clench your teeth?	Y/N
Do you smoke?	Y/N	Do you wear a dental night guard?	Y/N
Do you bite your lips or cheeks often?	Y/N	Do you think you suffer from bad breath?	Y/N
Does floss ever tear between your teeth?	Y/N	Does food get trapped between your teeth?	Y/N
Do you use a fluoridated toothpaste?	Y/N	Do you use interdental brushes or a water irrigator?	Y/N
How often fo you floss?			
Are you happy with the appearance of your teeth?	Y/N		
If not, how would you like us to help?			

Integrated Dental Health

A Holistic Approach

Welcome to Integrated Dental Health

Our team are dedicated to providing you with gentle & complete dental care in a relaxing environment.

We believe treatment should integrate as closely as possible with the body's processes and structures. Our dentists look at the effects of dental disease on your general health and vice versa to achieve the best outcome. We use materials and procedures that work in harmony with your body, caring for your overall health & well being.

Our focus is on holistic health and we also believe well researched, tried & tested procedures which might include implants and root canal therapy.

How important is holistic dentistry to you?

Routine dentistry is all I need	1	2	3	4	5	6	7	8	9	10	**I want all the holistic options available**

Please list any specific holistic needs you wish to discuss with the dentist

How do you feel about seeing the dentist?

Please indicate on this chart where you feel is the most applicable to you:

Relaxed	1	2	3	4	5	6	7	8	9	10	**Extreme Fear**

Are you interested In any of the following services?

☐ Facial injectables	☐ Safe amalgam removal
☐ Ceramic restorations	☐ Naturopathic consult prior to amalgam removal
☐ Whitening	☐ Implants
☐ Treatment under sedation	☐ Complimentary acupuncture with Dr Henriette
☐ Multidisciplinary consultation with allied health practitioners	

How did you hear about us?

☐ Walked by	☐ Facebook	☐ Google	☐ Word of Mouth**	☐ Other

**Who can we thank for referring you to us?

Private health fund details

Name of health fund:	
Membership number:	What number are you listed on the card:

Consent For Treatment

1. I hereby authorise the dental practitioners to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis.
2. Upon such diagnosis, I authorise the dental practitioner to perform all recommended treatment mutually agreed upon by me.
3. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand that full payment is due at the time of service unless other arrangements have been made.
4. Please tick here if you do not wish to receive our internal correspondence ☐
5. Under such diagnosis, I authorise my dental records, x-rays, study models, photographs, and other diagnostic aids deemed appropriate to be shared with surgical dentists and specialists.

Patient/Guardian Signature: _____ **Date:** ____/___/_____

Please turn over→→→