MYTOOTHDOCTOR™
GARRET ROBLES, DMD

Project Outback Dental (POD) Pty Ltd®

Welcome to MyToothDoctor Townsville Paediatric and Family Dentistry at the Aitkenvale Family Health Centre, the city surgery of Project Outback Dental (POD) Pty Ltd.

Please take a few minutes to fill in this form as completely as possible. If you have any questions we will be happy to assist. Your information is subject to strict confidentiality.

We look forward to working with you in maintaining your oral health.

Date: _____

NEW PATIENT INFORMATION

Patient Name: Last _____ First _____ Middle _____
If you are under 16, Parent or Guardian's Name: _____
Home Address: _____
Postal Address (if different from above): _____
Date of Birth _____/_____/_____ Gender: _____
Contact Number: _____Preferred method of communication: Call ____
Email address: _____ Text ____
Email ____
Medicare Card Number: _____ Individual Reference Number on Medicare card: _____
Private Health Fund: _____
Who may we thank for referring you to our Dental Surgery? _____

It is important that I know about your medical and dental history. These facts have a direct effect on your overall health and well-being. This information is subject to strict confidentiality of information. (Mark the appropriate response).

DENTAL HISTORY	MEDICAL HISTORY	
HOW LONG SINCE your last visit to the dentist	Are you currently undergoing medical treatment? Yes No	
Date of LAST COMPLETE DENTAL EXAM	What MEDICATIONS are you currently taking?	
Date of LAST FULL MOUTH X-RAY	Are you PREGNANT? Yes No	
Are you having PROBLEMS now Yes No	Do you use cigars/cigarettes, pipe or chewing tobacco?	
Explain briefly	Are you allergic to any medication or material? (i.e. Penicillin, Latex)	
Do you wear DENTURES Yes No Partial or Full	MARK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:	
Are you UNHAPPY with your dentures? Yes No		
Are you apprehensive about dental treatment? Yes No	High/Low Blood Pressure	Heart Complaint
Do your gums BLEED, or FEEL TENDER or IRRITATED?	Rheumatic Fever	Asthma or Breathing Problems
Are your teeth SENSITIVE to hot, cold, sweets, pressures?	Allergies or Hives	Steroid Therapy
Do you use DENTAL FLOSS regularly? Yes No	Arthritis	Kidney Disease
Are you aware of GRINDING or CLENCHING of your teeth?	Stroke	Tuberculosis
Do you have HEADACHES, EARACHES or NECKPAINS?	Emphysema	Sinus Therapy
Have you worn BRACES on your teeth? Yes No	Bleeding Disorder	Cancer
Do you have DISCOLOURED teeth that bother you?	Heart Surgery/Attack	Mad cow disease (CJD)
	Epilepsy	
	Diabetes	
	Hepatitis A, B, C	
Please rank the following in the order in which they would KEEP YOU FROM having dental treatment FEAR OF PAIN COST OF TREATMENT MISSING WORK TIME NOT TOO CONCERNED ABOUT MY TEETH	Is there anything else you would like to tell us about your general health?	
	Who is your usual GP? Suburb Phone Number	