smile with confa-dental
advanced denture lab

PATIENT ASSESSMENT

In order to provide dental treatment of a high standard,
it is necessary to have the following information provided which will be handled confidentially:

DATE ……/……/……

NAME (Surname): ……(Given Names)……

ADDRESS: ……**AREA CODE**……

TELEPHONE: (Business): ……(Private): ……(Mobile): ……

OCCUPATION: …… **DATE OF BIRTH**:……/……/……

EMAIL ADDRESS: ……

PATIENTS DOCTOR: Name ……**PATIENTS DENTIST**: Name……

How did you hear about us? ……

Are you in a health fund for dental? YES / NO If so which fund:……Patient No.……

Are you covered by Veterans' Affairs (DVA)? YES / NO Number:……

Are you a Pensioner? YES / NO

Do you give permission for photographs of your teeth to be taken and displayed in this practice: YES/NO

SPECIFIC MEDICAL CONDITIONS: **Please answer each question.**

Heart Condition	Yes / No	Hepatitis / A.I.D.S (self or family)	Yes / No
Blood Pressure	Yes /No	Arthritis	Yes / No
Osteoporosis	Yes /No	Asthma	Yes / No
Cardiac Surgery / Pacemaker	Yes / No	Radiotherapy/Chemotherapy	Yes / No
Diabetes	Yes /No	Tuberculosis	Yes /No
Epilepsy	Yes /No	Mental/Physical Disability	Yes/No
Pregnancy	Yes/No		

How many sets of dentures have you owned: ……

How old are your current dentures? …… years.

ALLERIGIES:……
SOCIAL HISTORY: (Alcohol)…… (Smoker)……
RECENT MEDICATION:……
COMMENTS: ……
……

Please read and SIGN the back of this form

Phone: **4943 2299** Email: **admin@confa-dental.com**
70 Broad Street Sarina, Q, 4737 | GP Superclinic 13 Dutton Street, Walkerston, Q, 4751, | 1-3 Old Eimeo Rd, Rural View
ABN 95 056 532 506