PATIENT INFORMATION

Dr Thandar and Associates

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient Name:_____ Surname:_____

Date of Birth:_____ Sex: _____ Age:_____

Home Address:_____

_____

Postal Address:_____

_____

Home Phone:_____ Work: _____

Cell:_____ E-mail:_____

Occupation:_____ Employer:_____

Spouse's Name:_____ Phone:_____

Dependants:

Child Name:_____ Date Of Birth:_____

Child Name:_____ Date of Birth:_____

Child Name:_____ Date of Birth:_____

Medical Aid:_____ Med Number:_____

Name and Number of Medical Doctor:_____

Date of last visit to the dentist:_____

Referred By:_____

DENTAL HISTORY

Are you apprehensive about dental treatment?	Y	N	How often do your brush your teeth daily?	1	2
Have you had problems with previous dental treatments?	Y	N	How often do you floss? Once a day / Twice a day/ Once a week/ Once a month/ Never		
Do you gag easily?	Y	N	Do you use a mouth wash?	Y	N
Do you wear Dentures?	Y	N	Do you make use of a waterpic?	Y	N
Does food catch between your teeth?	Y	N	Do you currently have a manual or electric toothbrush?	M	E
Do you have difficulty in chewing your food?	Y	N	If manual is it a soft / medium or hard toothbrush?		
Do you chew only on one side of your mouth?	Y	N	How often do you visit the oral hygienist?		
Do you avoid brushing any part of your mouth because of pain?	Y	N	Do you clench or grind your jaw?	Y	N
Do your gums bleed easily?	Y	N	Does your jaw ever feel tired?	Y	N
Do your gums bleed when you floss?	Y	N	Does your jaw get stuck so that you can't open it freely?	Y	N
Do your gums feel swollen or tender?	Y	N	Does it hurt to chew or open your mouth wide?	Y	N
Do you feel twinges of pain when your teeth come into contact with: Hot food or liquid? Cold Food or liquid? Sours? Sweets?	Y	N	Do you have earaches or pain in front of your ears?	Y	N
Are your teeth sensitive?	Y	N	Do you have any jaw symptoms or headaches upon awaking in the morning?	Y	N
Do you take fluoride supplements?	Y	N	Are you unable to open your mouth as far as you would want?	Y	N
Do you want complete dental care?	Y	N	Do you have a temporomandibular (JAW) disorder? (TMJ)	Y	N
Do you prefer to save your teeth?	Y	N	Do you currently wear a night guard / bite plate?	Y	N
Are you interested in dental cosmetics?	Y	N	Do you take medication for pain or discomfort caused by your jaw?	Y	N
Are you dissatisfied with the appearance of your teeth?	Y	N	Does your jaw make a noise?	Y	N
Are you aware of dental cosmetic procedures?	Y	N	Have you had any trauma to your jaw?	Y	N

MEDICAL HISTORY

Heart Problems	Y	N	Blood Problems	Y	N
• Chest Pain	Y	N	• Easy Bruising	Y	N
• Shortness of Breath	Y	N	• Frequent Nose Bleeds	Y	N
• Blood Pressure Problems	Y	N	• Abnormal Bleeding	Y	N
• Heart Murmur	Y	N	• Anaemia	Y	N
• Heart Valve problem	Y	N	• Ever Required a Blood transfusion	Y	N
• Taking Heart Medication	Y	N	• Taking Anticoagulants (Blood Thinners)	Y	N
• Rheumatic fever	Y	N	Allergy Problems	Y	N
• Pacemaker	Y	N	• Hay Fever	Y	N

• Artificial heart valve	Y	N	• Sinus Problems	Y	N
Intestinal Problems	Y	N	• Skin Rash	Y	N
• Ulcer	Y	N	• Taking allergy medication	Y	N
• Weight gain or loss	Y	N	• Asthma	Y	N
• Special Diet	Y	N	Bone or Joint Problems	Y	N
• Constipation/Diarrhoea	Y	N	• Arthritis	Y	N
• Kidney or bladder problems	Y	N	• Back or neck pain	Y	N
Other	Y	N	• Joint Replacement	Y	N
• Fainting Spells, Seizures, or Epilepsy	Y	N	Are you allergic, or have you reacted adversely to any of the following:		
• Stroke	Y	N	• Local Anaesthesia	Y	N
• Frequent or severe headaches	Y	N	• Penicillin or other antibiotics	Y	N
• Thyroid Problems	Y	N	• Sulpha Drugs	Y	N
• Persistent Cough or swollen gland	Y	N	• Sedatives / Sleeping Pills	Y	N
• Diabetes	Y	N	• Aspirin / Ibuprofen	Y	N
• Tuberculosis	Y	N	• Codeine / Other narcotics	Y	N
• Do you drink alcohol	Y	N	• Reaction to metals	Y	N
• Do you smoke?	Y	N	• Latex or rubber dam	Y	N
• Hepatitis, Jaundice or liver trouble	Y	N	During the last 12 months have you taken any of the following?		
• HIV-positive/ Aids	Y	N	• Antibiotics or sulpha drugs	Y	N
• Glaucoma	Y	N	• Anticoagulants	Y	N
• Do you wear contact lenses	Y	N	• High blood pressure medication	Y	N
• History of head injury	Y	N	• Tranquilizers	Y	N
• Epilepsy or any other neurological disease	Y	N	• Insulin	Y	N
• History of alcohol or drug abuse	Y	N	• Aspirin	Y	N
• Do you have any other diseases, or conditions not specified above?	Y	N	• Nitro-glycerine	Y	N
• Please specify:			• Cortisone	Y	N
Women			• Natural remedies	Y	N
• Are you taking contraceptives or hormones	Y	N	• Non-prescription drugs	Y	N
• Are you pregnant	Y	N	• Other medication:		
• Are you nursing	Y	N			
• Have you reached menopause	Y	N			

PLEASE MOTE:

You are requested to pay after each consultation, and then submit your paid statement to your medical aid for reimbursement. You are personally responsible for your account, as this practice is not contracted with medical aid schemes. Interest will be charges on accounts that are not settled within 30 days from date of treatment.

The patient hereby agrees that in the event that Dr Thandar is obligated to instruct attorneys for the recovery of any amounts due and payable to him in respect of professional services rendered to the patient, that the patient undertakes and agrees to effect payment of all costs and disbursements incurred by Dr Thandar on a scale as between Attorney and Own Client, including costs of collection commission and any tracing fee.

Signature:_____ Date:_____