Medical and Dental History Form

It is important to know details about your medical history as these could affect the success of your dental treatment and how we can provide this treatment safely for you. Please note that all information on this medical & dental history form will remain strictly confidential.

PATIENT DETAILS.

Title	Mr./Mrs./Miss./Ms./Master (Other)		
Given Names			
Surname			
Occupation		Date of Birth	/ /
Home Address			
Phone	☐ H: ☐ W: ☐ M: Please tick which number you would prefer us to contact you on		
Email Address			
Health Fund (If applicable)	Number: Reference number:		
Emergency Contact	Name: Number: Relationship:		

MEDICAL HISTORY.

Name of your Doctor:		Your Doctor's Phone Number:	

Have you ever had or are you suffering from any of the following? Please tick that apply:

☐ Heart Disorder/Complaint	☐ Fainting Disorder	☐ High/Low Blood Pressure
☐ Diabetes	☐ Kidney Disease	☐ Sleep Apnoea
☐ Asthma	☐ Excessive Bleeding	☐ Prosthetic Implant
☐ Steroid Therapy	☐ Stroke	☐ Cardiac Pacemaker
☐ Radiation Therapy	☐ Cancer	☐ Hepatitis or Other Liver Disease
☐ Rhematic Fever	☐ Tuberculosis	☐ Lung Disease (eg. Bronchitis)
☐ Bone Disease – Osteoporosis	☐ Nervous or Psychiatric Condition	☐ Stomach or Digestive Condition
☐ Epilepsy	☐ Thyroid Disease	☐ Blood Disease (eg. Anaemia)
☐ Allergy to Penicillin	☐ Allergy to Medications	☐ Allergy to Latex

Do you require Antibiotic Cover?	
Any other Condition(s) not mentioned (Please list):	
For Women: Are you pregnant?	Are you breastfeeding?

Have you been a patient in hospital during the past 2 years? If yes, please provide more information.	
Are you taking any medication? If yes, please provide more information.	
Do you smoke? If so how many per day?	

DENTAL HISTORY.

Are you concerned about or experiencing any of the following dental problems? (Please tick as many as it applies)

☐ **Sensitivity to hot or cold**	☐ **Food trapping between teeth**	☐ **Clicking/pair in the jaw joints**
☐ **Staining of your teeth**	☐ **Discoloured fillings/teeth**	☐ **Roughness of existing fillings**
☐ **Bleeding gums**	☐ **Bad breath**	☐ **Sensitivity when eating**
☐ **Head/Neck Ache**	☐ **Grinding/clenching of your teeth**	☐ **Existing crowns/bridges/dentures**
What is the main purpose of your visit today?		
How long since your last dental visit?		

Does dental treatment make you nervous? **No** ☐ **Slightly** ☐ **Moderately** ☐ **Extremely** ☐

Have you ever had or require the following for dental treatment?

Gas (Nitrous oxide-laughing gas) **Intravenous sedation** **General Anaesthesia**

REFERRAL INFORMATION

Internet/Website ☐ **Walk-By** ☐ **Brochure in Letter Box** ☐ **Other** _____

Friend/Family (Please provide name so that we can thank them): _____

CONSENT FOR SERVICES:

I, the undersigned, **consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the** use **of local anaesthetic and other medication as indicated and I will assume responsibility for the fees** associated with **those procedures.**

I understand that the practice requires at least 24 hours notice if I need to cancel my scheduled appointment and that a cancellation fee may be incurred if I fail to do so.

I hereby authorize the dentist or the designated team to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.

I am aware that payment is required on the day of treatment.

We provide a courtesy to our patients a preventative recall program that offers a call service if you have not been to the practice in 6 months.

Patient/Parent/Responsible Person Signature: _____ **Date:** _____