NEW PATIENT MEDICAL & DENTAL HISTORY FORM

Please note that all information on this medical/dental form will remain strictly confidential. Please complete in **CAPITAL LETTERS**

Surname		Given Names	
Date of Birth		Occupation	
Phone (H) Phone (W) Phone (Mobile)	o o o (Please tick the box that you prefer we contact you on)	Home Address	
Email Address			
Health Fund		Health Fund Patient Number	
Emergency contact (please provide name and phone number)			

To complete only if the patient is under 18 years old

Guardian Name & Contact Address/Phone Details	

Referral Information

- o Internet/Website
- o Drove Past
- o Yellow Pages
- o Local Directory
- o Flyers
- o Word Of Mouth
- o Patient (please provide name so we can thank them) ………………………..

MEDICAL HISTORY

Name of your GP:		Your Doctor's Phone No.	
Your Doctor's address:			

Have you ever had any of the following? Please tick those that apply:

o Anaemia	o Fainting	o Pacemaker
o Artificial joints	o Glaucoma	o Radiation Therapy
o Asthma	o Heart Disease	o Respiratory problems
o Blood Disease	o Heart Murmur	o Rheumatic fever
o Cancer	o Hepatitis A, B, C	o Sinus problems
o Dizziness	o Jaundice	o Stroke
o Epilepsy	o Kidney Disease	o Tuberculosis
o Excessive Bleeding	o Liver Disease	o Tumours
o Diabetes	o HIV/ AIDS	o Psychological Disorders
Are you pregnant? **If yes, how many months?**		

Have you had any serious illnesses in the last 2 years? If yes, please provide more information.	
Are you currently taking any medications or tablets regularly? If yes, please provide more information.	
Do you have any allergies to Penicillin or other drugs? If yes, please provide more information.	
Do you suffer from sleep apnoea?	
Is your blood pressure normal, high or low?	
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)

- o sensitivity too hot or cold
- o staining of your teeth
- o bleeding gums
- o head/neck ache
- o food trapping between your teeth
- o discoloured fillings
- o bad breath
- o grinding or clenching of your teeth
- o clicking/pain in the jaw joints
- o roughness of existing fillings
- o sensitivity when eating

Are you concerned with: (please tick as many as it applies)

- o Existing crowns, bridges or dentures
- o Tooth clean techniques (e.g. Brushing / Flossing)
- o Crooked teeth
- o Wrinkles (e.g. Frown, smokers, forehead lines, crow's feet, etc)
- o Ability to eat
- o Your smile
- o Missing teeth
- o Migraines, Jaw Disorders
- o Gaps between your teeth
- o Discolouration of your teeth
- o Silver fillings
- o Facial Fillers (e.g. Lip enhancement)

What is the main purpose of your visit today?

____

How long since your last dental visit? ________________________________

Does dental treatment make you nervous?

o No o Slightly o Moderately o Extremely

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

o Gas (Nitrous oxide/happy gas) o Intravenous Sedation o General Anaesthesia

CONSENT FOR SERVICES

o I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated and I will assume responsibility for the fees associated with those procedures at time of treatment.

o I understand that the practice requires at least 24 hours notice if I need to cancel my scheduled appointment and that a cancellation fee of $50.00 could be incurred if I fail to do so.

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

o We provide as a courtesy to our patients a preventative recall program that offers a letter service if you have not been to the practice in 6 months. Do you wish to receive a recall letter from the practice in the event that you have missed your recall? _ Yes _ No Would you prefer _ Email _ SMS _ Letter

o As a courtesy would you like an SMS reminder of your appointment time the day before sent to your mobile phone? _ Yes _ No

______________________________ ______________________________

Patient Signature Date of Signature