dental design studio 32

New Patient Medical & Dental History Form

Please take the time to answer all questions carefully, your answers are important to us.

Patient Details

Surname_____ Given Names_____

Date of Birth_____ Phone (H)_____ □

Home Address_____ Phone (W)_____ □

_____ Phone (M)_____ □

Occupation_____ Please tick the box that you prefer we contact you on.

Email Address_____

Health Fund:_____ Member Number:_____

Emergency Contact: _____Please provide name and phone number.

Referral Information: □ Internet/Website □ Advertisement □ Walked Past □ Other

□ Another Patient. (Please provide name so that we can thank them)_____

Guardian Name, Contact Address and Phone Details (If the patient is under 18 years of age)

_____

Medical History

Doctor's Name: _____ Doctor's Phone Number: _____

Doctor's Address_____

Do you have or have you ever had any of the following? Please tick those that apply:

□ Anaemia	□ Artificial Joints	□ Asthma	□ Blood Disease	□ Cancer
□ Dizziness	□ Epilepsy	□ Excessive Bleeding	□ Diabetes	□ Fainting
□ Depression	□ Heart Disease	□ Hepatitis A, B, C	□ Jaundice	□ Kidney Disease
□ Liver Disease	□ HIV/AIDS	□ Pacemaker	□ Radiation Therapy	□ Respiratory Problems
□ Stroke	□ Tuberculosis	□ Tumours	□ Sinus Problems	□ Rheumatic Fever
□ Glaucoma	□ Bisphosphonate therapy		□ Psychological Disorders	

Are you pregnant? If yes, how many months? _____

Do you smoke? If yes, how many per day?_____

Have you had any serious illnesses in the last 2 years? _____

Are you currently taking any medications or tablets regularly? _____

Do you have any allergies to Penicillin or other drugs? _____

Do you suffer from sleep apnoea? _____

Is your blood pressure normal, high or low? _____

Are you on Warfarin therapy? If yes, please provide current INR._____

If yes to any of the above, please provide more information.

Please turn over

Dental History

Are you experiencing any of the following? Please tick all those that apply.

□ Sensitivity to hot or cold
□ Staining of your teeth
□ Bleeding gums
□ Head/neck ache
□ Food trapping between your teeth
□ Discoloured fillings
□ Bad breath
□ Grinding or clenching your teeth
□ Clicking/pain in the jaw joints
□ Roughness of existing fillings
□ Sensitivity when eating

Are you concerned with: Please tick as many as applies

□ Existing crowns or bridges
□ Tooth cleaning technique
□ Crooked teeth
□ Loose, uncomfortable or ill-fitting dentures
□ Ability to eat
□ Your smile
□ Amalgam (silver) fillings
□ Missing teeth
□ Gaps between your teeth
□ Discolouration of your teeth
□ Previous dental treatment
□ Wisdom teeth

As a part of a comprehensive dental examination it is standard procedure for 2 bite wing x-rays to be taken. These x-rays are taken to check for decay under any existing restorations or between the teeth where it is difficult to see with the naked eye, and should routinely be taken every 2 years. Please indicate if you would like these x-rays taken:

□ Yes □ No □ I would like more information or to talk to the dentist before deciding

Signature _____

How long since your last dental visit? _____

Does dental treatment make you nervous? _____

If you could change one thing about your smile, what would it be? _____

_____

_____

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 anaesthetics 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 of $50.00 could be incurred if I fail to do so.
- I hereby consent to the use of any study models, x-rays, computer images and photographs at various dental seminars, lectures and publications that the dentist may author.
- I am aware that payment is required on the day of treatment.
- We provide as a courtesy to our patients a preventative recall program that offers a recall card or call service if you have not been to the practice in 6 months. I understand I will be entered onto such a recall list.

X _____ _____

Patient Signature Date of signature