818 Dental

Medical History | Adults

As part of our commitment to provide you with the best possible care & service, we aim to update your medical history regularly. Please take a few moments of your time to complete this form.

Title: _____ First Name: _____ Surname: _____

Date of Birth: _____ Occupation: _____

Home Address: _____

Mobile: _____ Phone (Home): _____ (Work): _____

Email: _____

We confirm all of our patients appointments – which method do you prefer? SMS / Email / Phone

How did you hear about our practice? (Internet, Facebook, Patient etc) _____

(If you were referred to us by an existing patient please list their name so we can thank them) _____

Do you have Private Health Insurance? YES / NO Health Fund Name _____

Dental History Questionnaire

What is the reason for your visit today? _____

When did you last have x-rays? _____

When was your last appointment? and what treatment did you have done? _____

_____

Why did you decide to leave your previous dental clinic? _____

Are you happy with the appearance/colour of your teeth? If no, why? YES / NO _____

Are your teeth sensitive to Hot / Cold / Biting pressure? If yes, please list. YES / NO _____

Do you grind / clench your teeth? YES / NO _____

Do your gums bleed when brushing or flossing? YES / NO _____

Are there any aspects of dentistry you would like to ask us about today? _____

_____

Kindly turn over the page to complete the Medical History section

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Medical History

Name and phone number of Medical Practitioner: _____

Have you ever been hospitalised? If so for what? _____

Are you currently taking any medications? If yes please list name/dosage _____

_____

Are you allergic to anything? Anesthetic / Penicillin / Antibiotics / Other? _____

Do you smoke? YES/NO Are you pregnant? (Ladies) YES/NO? Which Trimester? 1 / 2 / 3

Please circle if you have any of the conditions listed below:

High blood pressure	Aids or HIV infection	Hepatitis
Heart / Kidney / Liver Disease	Cardiac Pacemaker	Heart Murmur
Stroke	Diabetes	Tuberculosis
Asthma	Cancer	Hip / Knee Replacement

Privacy Policy Act

This practice adheres to the ADA privacy policy. Records are only collected with the patient's written consent. These records are for use by 818 Dental only where relevant to our dental function and are kept confidential. Patients can request a copy of their records of treatment be sent to another health professional. 48hours 'notice must be given and may incur a $50 processing/administration fee.

Patient Consent

I certify that I have read and understand the above information. To the best of my knowledge, the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient / Parent / Guardian **Date**

_____ _____