Medical History & Dental Questionnaire

Patient information

Surname: ______________________________

Given name: ____________________________

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr

Date of birth ___/____/_____

Address: _______________________________

____

Postcode_____________

Home phone: ___________________________

Mobile: ________________________________

Email__________________________________

Parent / Guardian details (if under 19)

Name: _________________________________

Address: _______________________________

Phone: _________________________________

Emergency contact person

Name: _________________________________

Phone: _________________________________

Health fund information

Fund name: ___________________________

Fund number: _________________________

Patient number: _______________________

Other

Medicare number: ______________________

Medicare series number: ________________

Veteran's affairs number: ________________

Smiles number: ________________________

Smiles exp date: _______________________

Other: _________________________________

Referral information – how did you find us?

☐ Internet ☐ Walking by ☐ Radio ☐ Yellow pages ☐ Local search

☐ Family/ Friend _____________________ ☐ Referral ___________________________

☐ Other ____

Consent for contacting General Medical Practitioner

I, the undersigned, give my Dental Practitioner at Family Dental Group, permission to contact my General Practitioner or Specialist, **if required**, in the course of my dental treatment, to obtain or discuss issues that are relevant to my health.

I understand that this will be done in accordance with the Privacy Act and will be confidential

Patient/parent/guardian signature: _________________________________ Date: _____________

GP name: ___________________________________ GP contact number_______________________

Medical history

Have you ever had, or do you suffer from, any of the following? Please ☑ those that apply:

☐ Arthritis
☐ Asthma
☐ Blood disease
☐ Blood pressure
☐ Bone disease/ Osteoporosis
☐ Cancer
☐ Chemo/radiation therapy
☐ Cholesterol
☐ Diabetes
☐ Epilepsy
☐ Fainting disorder
☐ Heart disease/murmur/stent
☐ Hepatitis A/B/C
☐ Immune disorder
☐ Joint replacement
☐ Kidney disease
☐ Liver disease
☐ Lung disease
☐ Pacemaker
☐ Psychiatric condition
☐ Rheumatic fever
☐ Sinus problems
☐ Steroid therapy
☐ Stomach issues
☐ Stress disorders
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Pregnant_______________
☐ Breast feeding____________
☐ Smoker__________________
☐ Other_________________

How do you rate your overall **General Health**? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Are you currently taking any pills, medications, or supplements? ☐ No ☐ Yes→_______________________________________

Do you have any allergies to antibiotics, medications, latex or other substances? ☐ No ☐ Yes→ _______________________

Dental History

If you are experiencing any of the following, please ☑ all that apply

☐ Sensitivity to hot or cold
☐Rough existing fillings
☐ Lost fillings
☐ Tooth ache
☐ Tooth decay
☐ Loose or ill-fitting dentures
☐ Dry mouth
☐ Problems with previous dental treatment
☐ Pain on biting
☐Bleeding gums
☐ Discoloured fillings
☐ Crooked teeth
☐ Gaps between teeth
☐ Loose teeth
☐ Clicking or pain in the jaw
☐ Missing teeth
☐ Worn/broken teeth
☐ Bad breath
☐ Grinding or clenching
☐ Food trapping between teeth
☐ Staining of your teeth
☐ Ulcers/blisters/lumps
☐Problem with existing crown or bridge

Are you attending for a specific problem today? ☐ No ☐ Yes→____

How long ago was your last dental visit? ☐ Never ☐ 6mths or less ☐ between 1-2 yr ☐ between 2-5 yr ☐ over 5 yr

Does dental treatment make you feel nervous? ☐ Never ☐ Slightly ☐ Moderately ☐ Extremely

Are you satisfied with the appearance of your teeth? ☐ Yes ☐No →____

Do you have any other comments that would help the dentist with your treatment?_________________________________

Consent for service

∗ I, the undersigned to the best of my knowledge have provided accurate information relating to my health and if any changes are required I will notify the Dentist/Surgery as soon as is practicable.

∗ I consent to the performing of dental and surgical procedures agreed to be necessary or advised, and will assume responsibility for the fees associated with those procedures.

∗ I am aware that full payment is made on the day of treatment.

∗ This form will be electronically copied to your clinical record file and the original will be subsequently destroyed.

Name ___________________________________ Signature ________________________ Date _________________