

Shire Dental Centre

SURNAME: _____ GIVEN NAMES: _____

MEDICAL HISTORY

This Section is essential to us in providing safe medical treatment.

Have you ever had any of the following? Please for Yes.

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies to medication -
please specify: | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Healing Complications | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever / Endocarditis |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Hepatitis: Type _____ | <input type="checkbox"/> Stomach Disorder/Duodenal Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disorder/Bleeder | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> OTHER, please specify: |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> _____ |
| | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> _____ |

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- Do you smoke? If yes, how many per day? _____ Yes / No
 - Are you currently pregnant? _____ Yes / No
 - Are you currently taking any prescription medications or drugs? _____ Yes / No
 - If Yes please state: _____
 - Are you now under the care of a Specialist? _____ Yes / No
 - If Yes please explain: _____
 - Name of Specialist: _____ Phone: _____

The following section is not essential, however it does help us better serve your needs.

- Are you experiencing tooth sensitivity to any of the following?
 HEAT COLD SWEETS BITING PRESSURE
- Does food catch between your teeth? _____ Yes / No
- Do your gums bleed when brushing? _____ Yes / No
- Have you noticed any gum swelling around any teeth? _____ Yes / No
- Do you have an unpleasant taste or odor in your mouth? _____ Yes / No
- Do you suffer from recurring headaches? _____ Yes / No
- If Yes how often? _____
- Are you satisfied with your teeth and their appearance? _____ Yes / No
- When was your last dental appointment? _____
- What is your present dental concern? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at my next appointment without fail. I understand that all the health information given will be treated with privacy and confidentiality.

Authorisation of patient, parent or guardian: _____ Date: ___ / ___ / ___ (Please turn over)

Cancellation policy

We appreciate that your time is precious and we make every effort to run on time, therefore we ask that you also value our time by attending your appointment punctually and giving us at least 24 hours notice if you wish to cancel. Please note that if you cancel within 24 hours of your appointment a cancellation fee may apply.

PATIENT DETAILS

Patient Name: _____

Title Surname First Name Middle Name

Date of Birth: _____

Preferred Name: _____

Phone:

(H): _____ **(W):** _____ **(M):** _____

Address: _____

Street

Suburb

State

Post Code

Email Address: _____

Phone No. for confirmation of appointments:

Home

Work

Mobile

Email

Are you a member of a private health fund which covers you for dental?

Yes / No

If yes, which one? _____

REFERRAL INFORMATION

Which of our patients may we thank for referring you to our practice? Or how did you find out about us?

Which patient? _____

Yellow pages

Advertisement

Other, please specify _____

PARENT/GUARDIAN INFORMATION

Please ignore this section if you are over the age of 18

Name: _____

Date of Birth: _____

Relationship to patient: _____

Phone: (H): _____

(W): _____

(M): _____

Address: _____

Street

Suburb

State

Post Code

Authorisation of Parent or Guardian

I have read the above information and agree to its content.

Signature: _____

Parent/Guardian

Date: _____