Wellard Village DENTAL

Medical history form

Patient details

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Other: ______

Surname: ______________________ Given name: __________________ D.O.B: __ /__ /____

Residential address: ____

Suburb: _______________________ Postcode: ________ State: _______

Postal address (if different): ____

Home phone: _________________ Work phone: __________________ Mobile: __________

Email: ____

☐ We may send out email communications to you from time to time, including appointment reminders and our regular newsletter. If you are happy for us to do so, please indicate your agreement by ticking this box.

Occupation: ____________________ Company: ____________________

Private health insurer: ____________ Member #: ____________________ Patient #: _________

Medicare #: ______________________ Vets Affairs #: _________________ Expiry: ___________

Emergency contact: ______________ Phone: __________________ Relation: ________________

Preferred method of communication

☐ SMS ☐ Telephone ☐ Email ☐ Letter

Medical history

☐ Abnormal bleeding
☐ Angina
☐ Artificial heart valve
☐ Asthma
☐ Bone disease
☐ High/low blood pressure
☐ Blood thinner
☐ Cardiac surgery/pacemaker
☐ Congenital heart defect
☐ Diabetes type 1/type 2
☐ Epilepsy
☐ Heart murmur
☐ Hepatitis A/B/C/D
☐ HIV positive
☐ Kidney/liver disease
☐ MS
☐ Nervous disorder
☐ Oral cancer
☐ Pregnant
☐ Prosthetic hip
☐ Radiation/chemotherapy
☐ Reflux
☐ Rheumatic fever
☐ Sleep apnoea
☐ Steroid therapy
☐ Stroke
☐ Thyroid disorder

Are you Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

Are you taking medication? If yes, please list: ____

Are you a smoker? If yes, how often? ____

Dental allergies

☐ Penicillin ☐ Aspirin ☐ Iodine ☐ Sulpha drugs ☐ Latex

Other (please specify): ____

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Dental history

Last dental visit: __ / __ / ____

Have you ever had any reaction or complication following dental treatment in the past? If yes, please detail:

____

Is there anything else the dentist or hygienist should be aware of? ____________________________

Are you suffering from any of the following?

☐ Toothache ☐ Missing teeth ☐ Pain in face/jaw

☐ Sensitive teeth ☐ Unsatisfactory denture ☐ Sounds from joint

☐ Bleeding gums ☐ Rapidly decaying teeth ☐ Difficulty chewing

☐ Loose teeth ☐ Lost filling/cavity ☐ Discoloured teeth

☐ Bad breath ☐ Grinding/clenching teeth ☐ Bad appearance of teeth

☐ Dry mouth ☐ Worn or broken teeth

Have you ever had a sleep study and been diagnosed with sleep apnoea? ☐ Yes ☐ No

If yes, have you ever tried Continuous Positive Airway Pressure (CPAP) therapy? ☐ Yes ☐ No

Has anyone ever told you that you snore? ☐ Yes ☐ No

After 6-7 hours of sleep do you wake up refreshed? ☐ Yes ☐ No

How did you find out about us?

☐ Google ☐ Signage ☐ Website

☐ Mail Brochure ☐ Other (please specify): ______________________________________

Referred by friend/family: ____

On a scale of 1 – 10, with 10 being very comfortable and not at all anxious, how comfortable are you feeling about your appointment today?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Privacy policy & signature

Any information is collected and maintained in accordance with State and Federal Privacy Legislation. A copy of our privacy policy can be obtained online via our website. I have accurately completed this medical history form to the best of my knowledge. I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentists and their staff. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand that payment is due at the time of service unless other arrangements have been made. I authorise my dentist to take images of my teeth both before and after my treatment. I understand these images may be used in a practice portfolio to showcase examples of dental work to other patients and my identity will remain anonymous.

Patient name: ___________________________ Signature: __________________ Date: __ / __ / ____

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