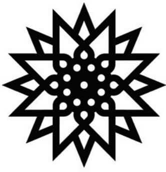

WaratahDental

NEW PATIENT MEDICAL & DENTAL HISTORY FORM

Please note that all information on this medical/dental form will remain strictly confidential. Please complete in **CAPITAL LETTERS. Complete in Black Pen.**

Surname		Dr, Mr, Mrs, Ms, Miss Given Names	
Date of Birth		Occupation	
Phone (H) Phone (W) Phone (Mobile)	❑ ❑ ❑ (Please tick the box that you prefer we contact you on)	Home Address Postal Address	
Email Address			
Health Fund		Member Number	
Emergency Contact (please provide name and phone number)			

To complete only if the patient is under 18 years old

Guardian Name & Contact Address / Phone Details	

Referral Information

❑ Internet / Website ❑ Walked Past ❑ Yellow Pages ❑ Newspaper ________ ❑ Radio ________

❑ Patient (please provide name so that we can thank them) ________________________________

MEDICAL HISTORY

Name of your GP:	Your Doctor's Phone No:

Have you ever had any of the following? Please tick those that apply:

Are you pregnant? If yes, how many months?	❑ Diabetes	❑ Stroke
❑ Artificial joints	❑ Hepatitis A, B, C	❑ Thyroid Problems
❑ Asthma	❑ Heart Disease	❑ Tuberculosis
❑ Arthritis	❑ Heart Murmur / Rheumatic Fever	❑ Other
❑ Bisphosphonates	❑ Kidney Disease	
❑ Blood Pressure	❑ Liver Disease	
❑ Cancer	❑ HIV / AIDS	
❑ Depression / Anxiety	❑ Radiation Therapy	
❑ Epilepsy	❑ Respiratory problems	
❑ Excess Bleeding	❑ Sinus problems	

Have you had any serious illness in the last 2 years? If yes, please provide more information	
Are you currently taking any medications or tablets regularly? If yes, please provide more information	
Do you have any allergies to Penicillin or other drugs? If yes, please provide more information	
Do you suffer from sleep apnoea?	
Do you smoke? If so how many per day?	

DENTAL HISTORY

Are you concerned about or experiencing any of the following dental problems? (please tick as many as it applies)

- ❑ 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 of your teeth
- ❑ clicking / pain in the jaw joints
- ❑ roughness of existing fillings
- ❑ sensitivity when eating
- ❑ mouth breathing

Are you concerned with: (please tick as many as it applies)

- ❑ Existing crowns, bridges or dentures
- ❑ Tooth clean techniques (e.g. Brushing / Flossing)
- ❑ Crooked teeth
- ❑ Missing teeth
- ❑ Ability to eat
- ❑ Your smile
- ❑ Silver fillings
- ❑ Gaps between your teeth
- ❑ Discolouration of your teeth
- ❑ Previous dental treatment
- ❑ Cosmetic procedures
- ❑ Whitening procedures

How long since your last dental visit? ____________________

Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderatley ❑ Extremely

Have you ever had or require the following for dental treatment?

❑ Gas (Nitrous oxide-laughing gas) ❑ Intravenous sedation ❑ General Anaesthesia

Consent for Treatment

1. I hereby authorise the dentist or diagnosed staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.

2. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistant as required to provide proper care.

3. I agree to the use of anaesthetics as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.

4. I agree that the above is a true and accurate record. I understand that Waratah Dental Surgery requires payment on the day of treatment. Any expenses, costs or disbursements incurred by Waratah Dental Surgery in recovering outstanding monies including debt collection fees and solicitor costs shall be paid by the responsible party above. I further acknowledge that failure to attend any appointment without notice may also result in a deposit requirement prior to future appointments being scheduled.

PLEASE NOTE: The medical history form will be electronically copied to your clinical record file and the original will be subsequently destroyed. By signing this document you agree to this process. This form is a guide only and you should discuss any relevant matters with your dentist prior to the commencement of any dental treatments.

Signature: .... Date:................/................/................