Current as at:

REFERRED BY:........................................................................................................

Welcome to Waratah Dental

WaratahDental

# Medical and Dental History

## Patient Information

| Title | First Name | Last Name | Date of Birth |
|---|---|---|---|
| Mailing Address | Suburb | Postcode | |
| Occupation | Emergency, contact: | (*relationship*) | Telephone number of Emergency Contact |

## Contact Preferences *(please tick the preferred contact number - SMS notification available)*

☐ Home ..........................................................................
☐ Work ..........................................................................
☐ Mobile ..........................................................................

Email ..........................................................................

## Do you have health insurance for dental treatment? ☐ Yes ☐ No

............................................................
Insurance Provider

**ALLERGIES**

| | Yes | No |
|---|---|---|
| Latex sensitivity | ☐ | ☐ |
| Penicillin | ☐ | ☐ |
| Other antibiotics | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| NSAIDS - Non steroidal anti-inflammatories | ☐ | ☐ |
| Codeine | ☐ | ☐ |
| x ..........................................Other Allergies | ☐ | ☐ |

**MEDICATIONS**

Please list any medication you are currently taking below:

*Medications*

| | Yes | No |
|---|---|---|
| Are you on medications for osteoporosis | ☐ | ☐ |

*Is there anything else you feel we should be aware of?*

*DATE OF LAST COMPREHENSIVE EXAMINATION:*

..........................................................................

**HAVE YOU HAD OR DO YOU CURRENTLY HAVE....**

| | Yes | No |
|---|---|---|
| Artificial/prosthetic joints/implants | ☐ | ☐ |
| Heart valve replacement/mitral valve prolapse | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ |
| Heart murmur | ☐ | ☐ |
| High blood pressure | ☐ | ☐ |
| Low blood pressure | ☐ | ☐ |
| Cardiac pacemaker | ☐ | ☐ |
| Other heart related problems | ☐ | ☐ |
| Snoring / Sleep apnoea | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Do you smoke | ☐ | ☐ |
| Anaemia / Other blood disorders | ☐ | ☐ |
| Bleeding tendency /abnormal bleeding | ☐ | ☐ |
| Hepatitis / Jaundice / Liver disease | ☐ | ☐ |
| Epilepsy or seizures | ☐ | ☐ |
| Thyroid trouble | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Stomach ulcers | ☐ | ☐ |
| HIV/AIDS | ☐ | ☐ |
| Problem with your immune system | ☐ | ☐ |
| Removable partial denture | ☐ | ☐ |
| Does your jaw click or hurt | ☐ | ☐ |
| Do you feel you grind your teeth | ☐ | ☐ |
| Do you wear a night guard | ☐ | ☐ |
| Jaw muscle pain | ☐ | ☐ |
| Do you experience bad breath | ☐ | ☐ |
| Have you ever had gum disease | ☐ | ☐ |
| Brushing makes your gums bleed | ☐ | ☐ |
| Does food get jammed in your teeth | ☐ | ☐ |
| Does floss tear between your teeth | ☐ | ☐ |
| Any hot/cold sensitivity | ☐ | ☐ |
| Do your teeth hurt on hard biting | ☐ | ☐ |

I have accurately completed this pre-clinical questionnaire to the best of my knowledge. I hereby give my authority for the dentist or designated team to take x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis. Upon such a diagnosis I authorise the dentists to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

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Signature (Parent or Guardian if patient is a minor)

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Date Signed