

Welcome to our practice. Please complete the following MEDICAL HISTORY form.

(Please Circle)

(Mr/Mrs/Ms/Miss/Other _____) First Name: _____ Surname: _____

Address: _____

Suburb: _____ P/code: _____ Date Of Birth: ____/____/____

Phone (Home): _____ Mobile: _____ Emergency Contact: _____

Email: _____ Occupation: _____

Private Dental Cover: Y/N _____ Name of health fund: _____

PLEASE TICK BOXES IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING.

	Y	N		Y	N
Any Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A B C D E	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Anaemia or other Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure Low/High	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid - Hypo/ Hyper	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumour History	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type 1 or 2	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE TICK BOXES IF YOU ARE CONCERNED WITH / INTERESTED IN ANY OF THE FOLLOWING:

Ability to eat Bad breath Bleeding gums Clenching/grinding Crooked teeth Discolouration
 Old bridges, crowns, dentures Gaps between teeth Missing teeth Silver fillings Teeth whitening
 Teeth clenching exercise Your SMILE Previous dental treatment _____

Reason for current visit: _____

Any other relevant conditions: _____

Any current medication(s): _____

Are you allergic to any of these? Penicillin Latex Others _____

Do you smoke? Y/N If yes the how many in a day/week/month: _____

How long was your last visit to the dentist? _____ **Have you had any X-rays in last 2 years? Y / N**

How did you find out about our practice?

Our website Our Facebook Page Walk by/ Drive by Signage board
 Friend/ Relative (Please Name) _____ Other _____

I agree to be responsible for payment of all the treatments at the time of the service.

Please give **24 HOURS** notice for changes to your appointment. ***A FEE WILL BE CHARGED FOR NON-ATTENDANCE***

Signature: _____

Date: ____/____/____