Dental as anything

New Patient Medical History Form

At Dental as Anything we strive to provide you with the highest possible care. To do this we need to collect personal information from you that include contact details and matters pertaining to your general health, both past and present. Without this information it is difficult for your dentist or hygienist to plan your care properly. Please be assured that this information is maintained in accordance with State and Federal Privacy Legislation.

How did you find us?	(please tick)		
Professional recommendation	Veterans Affairs	Signage	Patient Referral
Over 50's Living & Lifestyle Guide	Staff referral	Live in the area	Facebook
GP referral	Practice Website	Referred by family or friend	Google

Other: _____

Who may we thank for referring you? _____

Patient Information:

Title: Mr Mrs Miss Ms Dr

Surname: _____ Given Name: _____

Preferred Name: _____ Date of Birth: / /

Occupation: _____

Residential Address: _____ Suburb: _____ Postcode: _____

Billing Address (if different): _____ Suburb: _____ Postcode: _____

Phone (Home): _____ Mobile: _____

Phone (Work): _____ Preferred Contact No: _____

Email: _____

Medicare Number: _____ Position No: ___ Veterans Affairs Card Number: _____

Next of Kin	
In case of emergency whom would we contact?	
Name:	Relationship:
Phone:	

Medical History

How do you rate your general health? (Please tick) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you smoke? ☐ No ☐ Yes, _____ years. Have you ever smoked? ☐ No ☐ Yes, _____ years ago.

Name of your General Practitioner: _____ Suburb: _____

Have you had or are you suffering from any of the following?

(Please tick)

- ☐ Heart Trouble/Surgery
- ☐ Cardiac Pacemaker
- ☐ High/Low Blood Pressure
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Hepatitis A B C D E
- ☐ Contact with blood-borne viruses
- ☐ Arthritis
- ☐ Thyroid Trouble
- ☐ Epilepsy
- ☐ Sleep Apnoea
- ☐ Stroke
- ☐ Steroid Therapy
- ☐ Bronchitis, emphysema or lung diseases
- ☐ Nervous Disorder
- ☐ Asthmatic
- ☐ HIV/AIDS
- ☐ Liver or Kidney Disease
- ☐ Rheumatic Fever
- ☐ Osteoporosis
- ☐ Anaemia, leukaemia or other blood diseases
- ☐ Eating Disorder
- ☐ Prosthetic Implant / Joint Replacement
- ☐ Stomach or Digestive Condition / Reflux
- ☐ Are you or could you be pregnant
- ☐ Excessive or Prolonged Bleeding
- ☐ Radiation or Chemotherapy
- ☐ Any other conditions

Other (Please specify): _____

Are you allergic to anything? Eg: local anesthetic, latex, penicillin, peanut, etc. _____

_____

What medications including natural remedies are you taking? _____

_____

_____

☐ I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist about this.

Have you or anyone in your household returned from overseas travel in the last 10 days? ☐ Yes ☐ No

Have you been hospitalised in the last 12 months? ☐ Yes ☐ No

Dental History

How long has it been since your last dental visit? Months: _____ Years:_____

Please tick any dental concerns you have:

- ☐ Bleeding Gums
- ☐ Worn, Broken Teeth
- ☐ Sounds from Joint
- ☐ Grinding / Clenching Teeth
- ☐ Bad Appearance of Teeth
- ☐ Missing Teeth
- ☐ Loose Teeth
- ☐ Difficulty Chewing
- ☐ Bad Breath
- ☐ Rapidly Decaying Teeth
- ☐ Unsatisfactory Denture
- ☐ Discoloured Teeth
- ☐ Dry Mouth
- ☐ Pain in Face or Jaw Joints
- ☐ Lost Filling / Cavity
- ☐ Toothache
- ☐ Sensitive Teeth

For Your Comfort

Whilst the improvement in techniques and anaesthetics have helped most people, you may still be apprehensive and wish us to take extra measures for your comfort. Please circle the number that indicates your present level of concern.

Completely at ease 1 2 3 4 5 6 7 8 9 10 Petrified

Consent for Treatment & Communications

- ❑ I am happy to receive SMS and Email communication from Dental as Anything for critical or pertinent appointment reminders and any other information that pertains to dental awareness, health fund or governmental changes.
- ❑ I hereby consent to dental treatment deemed necessary by the dentists and agreed by my verbal consent beforehand to be carried out. I understand that it will be discussed with me before any staff takes x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.
- ❑ I agree to be responsible for the payment of all services rendered on my behalf and on behalf of my dependants. I understand that payments are due at the time of service.

Patient / Guardian Name:_____ Signature: _____ Date: _____