Tatura Dental Care

Medical History

Welcome to our practice!

For our records and to assist in determining your treatment, please answer the following questions as accurately as possible.

All information will be treated with complete professional confidentiality.

☐ Mr ☐ Mrs ☐ Dr ☐ Ms ☐ Miss ☐ Other		
FAMILY NAME:		
GIVEN NAMES:	PREFERRED NAME:	
RESIDENTIAL ADDRESS:		
POSTAL ADDRESS:		
HOME PHONE:	MOBILE:	WORK:
PLACE OF WORK:	OCCUPATION:	
EMERGENCY CONTACT NAME:	PHONE:	
DO YOU HAVE PRIVATE HEALTH INSURANCE WITH DENTAL EXTRAS? ☐ YES	☐ NO	
NAME OF FUND:	NUMBER:	
MEDICARE NUMBER:	REF:	
MEDICAL DOCTOR:		
ADDRESS:	PHONE:	

Name of person responsible for fees if not paying yourself: _____.

Who can we thank for recommending our practice to you?_____.

What is the reason for your visit with us today?_____.

What treatment would you like to have done today?_____.

Are you pleased with the general appearance of your teeth and smile? ☐ Y ☐ N

Do you wish to keep your teeth for the rest of your life? ☐ Y ☐ N

Would you consider yourself to be anxious when visiting the dentist? ☐ Y ☐ N

Are you concerned about or experiencing any of the following dental problems? (Please select all that apply)

☐ Staining of your teeth	☐ Grinding or Clenching Teeth	☐ Gaps between your teeth
☐ Bleeding gums	☐ Discoloured Fillings	☐ Roughness of Existing Filling
☐ Bad breath	☐ Amalgam Fillings	☐ Denture fit / style / function
☐ Head or neck ache	☐ Clicking / Pain in jaw joints	☐ Missing teeth
☐ Crowding	☐ Sensitivity to hot / cold	

Do you wear any dentures or plates? ☐ Y ☐ N

Do you have any specific concerns about your teeth or mouth? ☐ Y ☐ N

Have you had any problems with dental treatment? ☐ Y ☐ N
If yes please describe:

Have you ever had, or do you have, any of the following? (Please tick)

	YES	NO		YES	NO
Epilepsy			High Blood Pressure		
Asthma			Low Blood Pressure		
Hepatitis			Rheumatic Fever		
Diabetes			Ladies are you pregnant		
Kidney Disease			Are you a smoker		
Bleeding Disorder			Sinus problems		
AIDS / HIV			Cancer		
Bone Disease including Osteoporosis			Radiation Therapy / Chemotherapy		
Transplanted organ or bone marrow			Steroid Therapy		

Do you have any heart problems?
☐ Attack ☐ Surgery ☐ Stents ☐ Bypass ☐ Pacemaker
☐ Other
Specialist Name:
☐ Yes ☐ No
How long ago? _____.

Do you have any joint replacement or prosthetic implants?
☐ Hip ☐ Knee ☐ Heart ☐ Other Prosthesis
Specialist Name:
☐ Yes ☐ No
How long ago? _____.

Are you allergic to any drugs, medicines or Latex?
Please List:
☐ Yes ☐ No

Have you ever had unusual effects from any medication or treatment? Please Explain:
☐ Yes ☐ No

Are you currently taking any medications?(prescription, over the counter or herbal) ☐ Yes ☐ No

For
For
For
For
For

Please list previous illnesses:

Your dentist is more than happy to discuss any medical details or concerns with you if you wish.

Thank – you for taking the time to complete this most important history sheet.

If you have any questions or comments, please feel free to ask our dentist or one of our team members.

On future visits, we would appreciate notification of any changes to the above.

Please read and sign your final declaration:

- I have completed this questionnaire to the best of my knowledge and ability, and understand that failure to make a full disclosure may place me at undue medical risk.
- I understand the practice requires at least 24 hours notice if I need to cancel or reschedule my appointment
- I am aware that payment is required on the day of treatment
- This medical history form will be electronically copied to my dental record file and the original will be subsequently destroyed. By signing this document I agree to this process.

Signature X_____.
Date _____/_____/_____.