CLIFTON HILL DENTAL

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Medical History Form

So we can ensure we are looking after your needs, please review and complete the following questionnaire:

Title: Mr/Mrs/Ms/other:	First name: Surname:
Date of birth:	Address:
Suburb and Postcode:	Home phone:
Work Phone:	Mobile:
Email:	Occupation:
Please select your preferred method/s of contact -Telephone ☐ -Sms ☐ -Email ☐ -Post ☐	
Would you like to receive appointment reminders? ☐ Yes ☐ No	
We may send occasional information, promotions or practice news out via email, please tick the box if you would like to receive them ☐	
Name of person responsible for fee, if not self:	

How did you find out about us? _____
Purpose of visit: _____
Dental Insurance company: _____

Have you had any of the following:

☐ Artificial Joints	☐ Allergy to Anaesthetics	☐ Hepatitis ABCDE
☐ Heart Problem	☐ Sinus trouble	☐ Diabetes
☐ Blood Pressure	☐ Tumour History	☐ Asthma
☐ Rheumatic Fever	☐ Allergy to Latex	☐ Epilepsy
☐ Stomach Ulcers	☐ Allergies to medications	☐ Liver/Kidney problems
☐ Excessive Bleeding	☐ Blood disorders	☐ HIV

Have you any other medical condition not listed above_____

Are you currently taking any medication Yes ☐ No ☐ If yes please list:

_____

PTO

Please tick if relevant:

□ Do you smoke?
□ Do your gums ever bleed when you Brush your teeth?
□ Have you ever had orthodontic treatment?
□ Do you wear a night guard?
□ Does floss ever tear between your teeth?
□ Do your teeth ever hurt when you bite hard?
□ Does your jaw click or hurt
□ Do you feel you grind your teeth?
□ Do you experience sensitivity with Hot /cold?
□ Have you ever had gum disease?
□ Have you ever had your bite adjusted?
□ Do you bite your lips or cheek often?

Other notes: _____

We now provide snoring and sleep apnoea services - please enquire with reception

The following questions will help us to help you with your sleep issues:

Have you ever had a sleep study ? □

Is snoring a problem for you, your family? □

Do you often feel tired, fatigued or sleepy during the day? □

Has anyone observed you stop breathing during your sleep? □

Do you have or have you ever been treated for high blood pressure? □

Name of your General Practioner:_____

Address:_____ Phone:_____

Are you pregnant? Yes, If yes what is the due date? _____

How long since your last dental appointment? _____

How often do you have dental examination? _____

Previous dental x-rays were taken Less than a year □ Longer than a year □

Consent for treatment

I hereby authorise the dentist or designated team to take x-rays, study model, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anaesthetics sedatives and other medication 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. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

I authorise that this data may be reviewed by team members of the dental practice.
We collect the information set out above in order to provide you with dental services. We will keep your information secure and confidential. If necessary, we may pass your information on to other health practitioners for a second opinion or referral purposes. We may also be required by law to provide your information to outside agencies. Our complete Privacy Policy is available to view at reception or on our website.

Patient/ Guardian signature: _____ Date: _____