ALDERLEY DENTAL
smiles from year to year

MEDICAL HISTORY

Title: _____ First Name(s): _____Preferred Name:_____ Last Name: _____

Date of Birth: _____ Occupation: _____

Address:_____

Email address: _____

Phone: Home: _____ Work: _____ Mobile: _____

Contact in case of emergency: _____ Phone: _____

Do you have dental health insurance:Y/N Which fund? _____Medicare Number: _____Exp: _____

In which country where you born? _____ Are you of Aboriginal Torres Strait or South Sea Islander origin? _____

Contact preference: ☐ Home phone ☐ SMS ☐Email ☐Letter

Referred by: ☐ Health fund ☐Street Sign ☐Medical Centre ☐Internet/ Google ☐Website ☐Google Review

☐ Friend/ Family (Please state name) _____

Medical Practitioner: Name/Address/Phone: _____

Are you under the care of a doctor? If so, for what reason? _____

Are you taking any medications at present? If so, what is it? _____

Are you taking blood thinners at present? eg. Warfarin _____ _____

Are you taking osteoporosis medicines at present? eg. Bisphosphonates, Fosamax, Actonel _____

Do you have any known allergies? E.g. Medications, latex _____

For Females, are you pregnant? If so, how many months? _____ Are you a smoker? If so, how many per day? _____

Do you normally require antibiotic cover before dental treatment? _____

Have you ever had an adverse reaction to any procedure performed by a dentist? _____

Have you ever had any of the following medical conditions? (Please tick the appropriate box and circle the appropriate condition)

Condition	**Yes**	**No**	**Condition**	**Yes**	**No**
High or low blood pressure			Diabetes: Type I, Type II		
Heart valve disorder or heart complaint			Organ or marrow transplant or blood transfusion		
Stroke			Epilepsy		
Cardiac pacemaker			Hepatitis: A, B or C or other liver condition		
Prosthetic implants or joints			Radiation therapy (please specify)		
Rheumatic fever			Stomach or digestive condition (please specify)		
Anemia or other blood condition			Asthma, bronchitis or other lung condition		
Excessive bleeding			Cancer or Tumor (please specify)		
Thyroid disease: Hyper-, Hypo-			HIV/AIDS		

Do you have any other illness or disability? Please specify: _____

1. I hereby understand that the failure to complete the medical information may place others and myself at risk.
2. I understand that this patient details / medical history questionnaire is treated with complete confidentially.
3. I understand that if I fail to give adequate notice to cancel my appointment, that a fee may be charged.
4. I agree to be responsible for payment of all services rendered on my behalf and on the behalf of my dependents. I understand that this payment is due at the time of service unless other arrangements have been made.

Patient signature: _____ Date: _____

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DENTAL HEALTH HISTORY

Do you experience sensitivity to hot/cold or sweet? ……	yes	no
Does food get jammed between your teeth? ……	yes	no
Do you brush and floss on a routine basis? …….	yes	no
Do your gums often bleed when you brush your teeth ….....	yes	no
Have you ever had periodontal (gum) treatment? ….....	yes	no
Have you ever had orthodontic treatment (braces)? ..……..	yes	no
Do you feel you grind your teeth? …….....	yes	no
Do you ever have clicking, popping, or discomfort in your jaw? …….	yes	no
Do you wear an occlusal splint? ……..	yes	no
Do you feel nervous about having dental treatment? ….....	yes	no
Have you ever had an upsetting experience in a dental office?…..…….	yes	no

How long since your last dental appointment? _____ How long since your last dental clean? _____

Is there anything else you would like us to know?

_____

_____

Whom may we thank for referring you? (Please state) _____

The greatest compliment we receive is when one of our patients refers a friend or family member to see us. If you were referred please tell us who to thank.

We occasionally would like to email you, as our patient, our monthly newsletter all of which you can unsubscribe from at any time. (Tick if you do not wish to receive communication via email) ☐

All information collected will be used for the purpose of providing treatment and processing health fund payments. This may include collation of medical/dental history & acquiring of digital x-rays, intra-oral images & photographs. If it is necessary your patient details & health information may be disclosed to other health care professionals only in the context of patient treatment.

Patient signature: _____ Date: _____