Confidential Medical and Dental History Form

□Mr □Mrs □Miss □Ms	**Full Name**:	**D.O.B:** / /
Phone Number: Home	Work	□ Mobile
Private Dental Cover? □ No	□ Yes	Fund Name:
Occupation:	**If under 18years Parents Name**:	
Home Address:		
Postal (if different):		
Email Address:		
Emergency Contact: Name:	Phone Number:	Relationship:

MEDICAL HISTORY:

Do you need Anti-Biotic cover for dental treatment? (i.e. heart condition/artificial joints) □**No** □**Yes**

Have you ever had or are suffering from any of the following? **Please tick all that apply**.

□ Diabetes	□ Kidney Disease	□ Prosthetic Implant
□ Heart Disorder	□ Excessive Bleeding	□ Cardiac Pacemaker
□ Asthma	□ Stroke	□□Stomach or Digestive Condition
□ Steroid Therapy	□ Cancer	□ Hepatitis A,B,C Or Other Liver Diseases
□ Radiation Therapy	□ Tuberculosis	□□HIV/AIDS
□ Rheumatic Fever	□ Thyroid Disease	□□Lung Disease(e.g. Bronchitis)
□ Bone Disease-Osteoporosis	□ Nervous or Psychiatric Condition	□□Blood Disease (e.g. Anaemia)
□ Epilepsy	□ High or Low Blood Pressure	□□Allergy to Penicillin
□ Fainting Disorder	□ Sleep Apnoea	□□Allergy to Medications
□ Any Other Condition(s)		□□Allergy to Latex
□ Ladies, is it possible you are pregnant? Due:		□□Blood Thinners

PLEASE LIST ALL MEDICATION THAT YOU ARE CURRENTLY TAKING and for what reason:

DENTAL HISTORY:

□□ Sensitivity to Hot or Cold	□ Food trapping between teeth	□ Grinding/Clenching of your teeth
□ Bad Breath	□ Discoloured filling/teeth	□ Clicking/Pain in the jaw joint
□□ Bleeding Gums	□ Smoker	□ Roughness of existing fillings
□□ Head/Neck ache	□ Floss tear between your teeth	□ Does it hurt when you bite hard?

What is the main purpose for your visit today?

How long since your last dental visit?

Does dental treatment make you nervous? □ No □ Slightly □ Moderately □ □ Extremely

Are you concerned with any of the following?

□□Existing crowns, bridges or dentures	□□ Ability to eat	□□ Gaps between your teeth
□ Teeth Cleaning techniques (brushing/flossing)	□□ Silver fillings	□□ Discolouration of your teeth
□□Crooked teeth	□□ Missing teeth	□□ Previous dental treatment

REFERRAL INFORMATION:

□ Yellow Pages □□ Street Sign □□ Web Site □□ Another Patient (name)

CONSENT FOR SERVICES:

▫I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic and other medication as indicated and I will assume responsibility for the fees associated with those procedures.

▫I understand that the practice requires at least 24 hour notice if I need to cancel my scheduled appointment and that a cancellation fee may incurred if I fail to do so.

▫I hereby authorize the dentist or the designated team to take x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis.

▫I am aware that payment is required on the day of treatment.

▫ I have read and agree to the above (our privacy policy is available on our reception counter)

Patient/Parent/Responsible Person

Print Name: Signature: Date / /