TOOTH 32

General & Cosmetic Dentistry

MEDICAL HISTORY FORM

Title	☐ **Dr** ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms** ☐ **Other**	
Surname		**Date of Birth**
First name	**Preferred name**	
Home address		
		Postcode
Postal address		Postcode
Phone: Mobile	Home	Work
Email		
Health fund for dental cover	Membership No.	Patient ID.
Medicare Card No.	Veteran's Affairs Card No.	
Occupation		
Emergency contact	Relationship to patient	Contact No.

When was your last dental examination?

What dental treatment, if any, was performed?

Have you ever been treated by a Dental Hygienist for professional cleaning of your teeth?

What would you like your ideal dental treatment plan to include? ie Teeth Whitening, Veneers, Implants

How did you hear about our clinic? ie yellow pages, website, signs, friends, family etc

Medical Questionnaire - Private and Confidential

Please answer these questions fully or discuss them with your dentist. Information about your medical history is for your dentist's use only.

Past/Current medical conditions:

Are you receiving any medical treatment at present?	Y ☐	N ☐	Details
Have you had any serious or long standing illnesses?	Y ☐	N ☐	Details
Have you had any operations in the last 12 months?	Y ☐	N ☐	Details

Please indicate if you have EVER had any of the following?

Any heart complaint/treatment	Y ☐	N ☐	Rheumatic fever	Y ☐	N ☐
High or low blood pressure	Y ☐	N ☐	Any nervous system disorder	Y ☐	N ☐
Bleeding disorders	Y ☐	N ☐	Gastric ulcer	Y ☐	N ☐
Reflux/stomach problems	Y ☐	N ☐	Asthma/bronchitis/lung condition	Y ☐	N ☐
Joint replacement surgery	Y ☐	N ☐	Radiation therapy/chemotherapy	Y ☐	N ☐
Osteoporosis or low bone density	Y ☐	N ☐	Thyroid disease	Y ☐	N ☐
Epilepsy	Y ☐	N ☐	Hepatisis, jaundice or liver disease	Y ☐	N ☐
Diabetes	Y ☐	N ☐	Treatment for any form of cancer	Y ☐	N ☐
HIV	Y ☐	N ☐	Transplanted organ or bone marrow	Y ☐	N ☐
Tuberculosis	Y ☐	N ☐	Pregnant (when due)	Y ☐	N ☐
Depression	Y ☐	N ☐	Breast feeding	Y ☐	N ☐
Any other medical details?	Y ☐	N ☐			

Do you smoke?	Y ☐	N ☐	
Current medications	Y ☐	N ☐	

Please list medications:

Do you require antibiotic cover prior to dental treatment? Y ☐ N ☐ Reason:

Allergies ☐ Nil known ☐ **Yes** - Details

Medical practitioner Suburb Phone

I agree that the above information is true and correct.
This form is a guide only and you should discuss any relevant medical history with your dentist prior to the commencement of any treatment.
I understand that TOOTH32 requires payment on the day of treatment.
I acknowledge that failure to attend an appointment without adequate notice may result in a deposit requirement prior to any future appointment being scheduled.
It would be much appreciated if you could please turn your mobile phone off or to silent mode before entering the consultation rooms.

PLEASE NOTE: *This medical history form will be electronically copied to your clinical record file and the original will be subsequently destroyed. By signing this document you agree to this process. This form is a guide only and you should discuss any relevant matters with your dentist prior to the commencement of any dental treatments.*

Signature **Date**

OFFICE USE ONLY	Form checked by:

Submit Save Print