BALACLAVA DENTAL CARE

NEW PATIENT Medical & Dental History form

PATIENT DETAILS:			
Title	Dr/ Mr/Mrs/Ms/ Miss /Master/(other)		
Given name			
Surname			
Occupation			
Company Name			
Date of birth	/ /		
Phone(H) Phone(W) Phone(M)	(please tick a box that you prefer we contact you)	Home address	
Email address			
Health Fund		Member Number	
Emergency Contact	Name: Phone Number: Relationship:		

Medical History:		
Name of Doctor:		
Your Doctor's phone number:		
Have you ever had or are you suffering from any of the following? Please:		
Diabetes	Kidney Disease	Orthopaedic Implant
Heart Disorder/Complaint	Excessive Bleeding	Asthma
Cardiac Pacemaker	Stroke	Stomach or Digestive Condition
Heart Murmur	Cancer	Hepatitis or Other Liver Diseases
High or Low Blood Pressure	Tuberculosis	Lung Disease (eg. Bronchitis)
Rheumatic Fever	Thyroid Disease	Blood Disease (eg. Anaemia)
Bone Disease– Osteoporosis	Nervous or Psychiatric Condition	Epilepsy
Sleep Apnoea	Radiation Therapy	Fainting Disorder
Any other condition(s) not mentioned (please list):		
Do you have any allergies?(Penicillin/ Medications/ Latex)		
For women: Are you pregnant? If yes, how many months?		
Have you been a patient in hospital during the past 2 years? If yes, please provide more information.		
Are you taking any medication? If yes, please provide more information.		
Do you smoke? If so, how many per day?	Yes/No	

Please turn over

Dental History:

What is the main purpose of your visit today?

How long since your last dental visit?

Are you concerned about or experiencing any of the following dental problems?
(please tick as many as it applies):

Sensitivity to hot or cold	Food trapping between teeth	Clicking/pain in the jaw joints
Staining of your teeth	Discoloured fillings/teeth	Roughness of existing fillings
Bleeding gums	Bad Breath	Sensitivity when eating
Head/Neck Ache	Grinding/clenching of your teeth	Existing crowns/bridges/dentures

Does dental treatment make you nervous?

No Slightly Moderately Extremely

Have you ever had or require the following for dental treatment:

Orthodontic treatment?
Periodontics treatment?
Oral surgery?
Gas (Nitrous-laughing gas)
General Anaesthesia

If so, did you have an upsetting dental experience?

Are you happy with the appearance of your teeth and smile? Yes/No

Would you like to have whiter teeth? Yes/No

Referral information: (How did you find out about us?)

Google Search	Our Practice Website	Billboard	Walk-in
Health fund website	Facebook	Yellow pages book	
Yellow pages online	Other:		

Friend/Family (please provide name so that we can thank them):

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 hours notice** if I need to cancel my scheduled appointment and that a cancellation fee may be incurred if I fail to do so.

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

I am aware that payment is required on the day of treatment (Please do not hesitate to discuss fees with your dentist).

I hereby take full responsibility to pay all accounts on the day of appointment, failing which I undertake to pay all extra charges associated with collection of fees.

Patient/Parent/responsible person signature_____ Date:_____