Patient Name_____ Date of Birth: _____

Address_____ Suburb_____

State: _____Post Code _____Occupation _____ Drivers Licence No _____

Phone: (H) _____ (W) _____ (Mobile) _____

E-mail address: _____

Emergency Contact: Phone: Relationship to contact:

How did you first hear about us? Please tick the appropriate box below.
□ Friend/Relative - Name:_____ □ Yellow Pages
□ Community Newspaper Please specify _____ □ Other Please specify _____

Welcome! So that we may provide you with the best possible care, please complete BOTH SIDES of this Medical/Dental History Form. All information is completely confidential.

What is the reason for you visit today? _____

Date of last dental visit._____ Last dental cleaning _____ Last full mouth X-rays _____

What was done at you last dental visit? _____

Previous Dentist's name_____

Address _____ State _____ P/Code _____

Telephone: _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other aids do you use? (Interplak, toothpick, etc) _____

Do you have any dental problems now? Yes/No

If yes, please describe: _____

Are your teeth sensitive to:

Hot or Cold?	Yes/No
Sweets?	Yes/No
Biting or Chewing?	Yes/No
Have you noticed any mouth odours or bad tastes?	Yes/No
A bite plate or a mouth guard?	Yes/No
Do you frequently get sores, blisters or any other oral lesions?	Yes/No

Do your gums bleed or hurt? Yes/No

Have your parents experienced gum disease or tooth loss?	Yes/No
Have you noticed any loose teeth or change in you bite	Yes/No
Does food tend to become caught between your teeth?	Yes/No
If so where?	

Do you:

Clench or grind your teeth while awake or asleep?	Yes/No
Bite your lip or cheeks regularly?	Yes/No
Hold foreign objects in your mouth? (Pencils, pipe, pins, nails, fingernails)?	Yes/No
Breathe through you mouth while awake or asleep?	Yes/No
Have tired jaws, especially in the morning?	Yes/No
Smoke/Chew tobacco?	Yes/No

Have you ever had:

Orthodontic Treatment?	Yes/No
Oral Surgery?	Yes/No
Periodontal Treatment	Yes/No
Your teeth ground or the bite adjusted?	Yes/No
Any previous problems with dental infections?	Yes/No
If so, please describe, including cause?	

_____

Have you experienced:

Clicking or popping of the jaw?	Yes/No
Pain (joint, ear, side of face)?	Yes/No
Difficulty in opening or closing the mouth?	Yes/No
Difficulty in chewing on either side of the mouth?	Yes/No
Headaches, neck aches, or shoulder aches?	Yes/No
Sore muscles (neck, shoulders)?	Yes/No
Are you satisfied with teeth's appearance?	Yes/No
Would you like to keep all of your teeth all of your life	Yes/No
Do you feel nervous about dental treatment	Yes/No
If so, what is your biggest concern?	

_____

Have you ever had an upsetting dental experience? Yes/No

If yes, please describe _____

PLEASE TURN OVER

1 Have you been under the care of a medical doctor during the past two years? Yes/No

If yes, for what? _____

Physician's Name _____ Phone _____

Address: _____ State _____ Postcode _____

2 Have you taken any medication or drug during the past two years? Yes/No

3 Are you taking any medication, drug or pill now? Yes/No

If yes, please list: _____

4 Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes/No

If yes please list: _____

5 Have you been a patient in the hospital during the past five years? Yes/No

6 Indicate which of the following you have had, or have at present. **Circle "yes" or "no" to each item**.

AIDS	Yes/No	Heart Murmur	Yes/No
Allergies or Hives	Yes/No	Heart Pacemaker	Yes/No
Arthritis/Rheumatism	Yes/No	Hepatitis please specify_____	Yes/No
Artificial Heart Valve	Yes/No	High Blood Pressure	Yes/No
Artificial Joints (hip, knee, etc)	Yes/No	HIV	Yes/No
Asthma	Yes/No	Kidney Trouble	Yes/No
Blood Transfusion	Yes/No	Lactose Intolerant	Yes/No
Bruise Easily	Yes/No	Latex Sensitivity	Yes/No
Chemotherapy	Yes/No	Liver Disease	Yes/No
Chest Pain	Yes/No	Mitral Valve Prolapse	Yes/No
Chronic Cough	Yes/No	Nervous / Anxious	Yes/No
Congenital Heart Disease	Yes/No	Neurological Disorder	Yes/No
Contact Lenses	Yes/No	Psychiatric/Psychological Care	Yes/No
Cortisone Medicine	Yes/No	Radiation Therapy	Yes/No
Diabetes	Yes/No	Rheumatic Fever	Yes/No
Diet (Special/Restricted)	Yes/No	Sickle Cell Disease	Yes/No
Emphysema	Yes/No	Sinus Trouble	Yes/No
Epilepsy / Seizures	Yes/No	Stroke	Yes/No
Fainting or Dizzy Spells	Yes/No	Swollen Ankles	Yes/No
Glaucoma	Yes/No	Thyroid Problems	Yes/No
Haemophilia	Yes/No	Tuberculosis	Yes/No
Hay Fever	Yes/No	Tumours	Yes/No
Heart (Attack, Disease, Surgery)	Yes/No	Ulcers	Yes/No
		Yellow Jaundice	Yes/No

7 Have you lost or gained more than 5 kilograms in the past year? Yes/No

8 Do you have or have you had any disease, condition, or problem not listed Yes/No

If yes, please list: _____

9 **Women**: Are you: **Pregnant?** Yes ___ Months No **Nursing?** Yes/No **Taking birth control pills** Yes/No

Is there anything about having dental treatment that you would like us to know? _____

If yes, please describe: - _____

Full payment is required on the day of treatment.

Payments Options are:
Full treatment plan payment cash in Advance entitles you to a 5%discount *CONDITIONS APPLY
Cash, Eftpos, Visa, MC, Amex,
EZI DEBIT Payment Plans

Which payment option is best suited to you _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist of any change in my health or medication.

Patient/Guardian Signature _____ Date _____