GOLDCITY DENTAL CENTRE

Confidential Medical and Dental History Form

PATIENT DETAILS

Mr Mrs Miss Ms	Full Name:	Date of Birth: / /
Phone Number: Home	Work	Mobile
Health Fund? Y / N	Email address:	
Home Address:		
Postal (if different):		
Emergency Contact: Name:	Phone Number:	Relationship

MEDICAL HISTORY:

Do you need Anti-Biotic cover for dental treatment? (ie heart disease/artificial joints) **No** **Yes**

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

○ **Diabetes**	○ **Kidney Disease**	○ Artificial Joints
○ Heart Disorder	○ Excessive Bleeding	○ **Cardiac Pacemaker**
○ **Asthma**	○ **Stroke**	○ Stomach or Digestive Condition
○ Steroid Therapy	○ Cancer	○ **Hepatitis A, B, C**
○ **Radiation Therapy**	○ **Tuberculosis**	○ HIV/AIDS
○ Rheumatic Fever	○ Thyroid Disease	○ **Lung Disease(eg Bronchitis)**
○ **Bone Disease-Osteoporosis**	○ **Nervous or Psychiatric Condition**	○ Blood Disease (eg. 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? Y N		○ Smoker - Per Day _____

Medication and reasons why taken:

DENTAL HISTORY:

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

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
Crowded 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.

Patient/Parent/Responsible Person

Print Name: Signature: Date / /