

MEDICAL HISTORY FORM

Paul A Trembath BDSc Qld
Dental Surgeon

Central Chambers
1407 Logan Rd
Mt Gravatt Q 4122

Welcome to our practice!

Please complete this Medical Questionnaire. All questions are relevant to modern dental practice and all information is strictly confidential.

Surname:..... Initials... Preferred first name.....
Mr/Mrs/Ms/Dr/Miss/Mast

Date of birth..... Occupation.....

Address.....Postcode.....

Telephone.....Work.....Mobile.....

Email address.....

It is our policy to give you a courtesy reminder call for your appointments when possible. Please tick your preferred contact method:

Phone:..... Mobile call:..... Mobile SMS:..... Email:.....

Do you have Dental Health Cover?..... Name of fund.....

Veteran Affairs Gold Card holder?

CONTACT IN CASE OF EMERGENCY:

Name.....Telephone.....

PLEASE ANSWER EVERY QUESTION

- I have confidential medical information that I do not wish to write down. I would prefer to speak to the dentist about this.

	Yes	No	Details
Are you being treated by a doctor at present?	<input type="checkbox"/>	<input type="checkbox"/>

Are you taking any medication or tablets?	<input type="checkbox"/>	<input type="checkbox"/>
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Have you ever had a prolonged illness? Or hospitalisation?	<input type="checkbox"/>	<input type="checkbox"/>	
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Do you normally require Antibiotic Cover before dental treatment? Eg for Heart Valve disorder? Prosthetic Joints?	<input type="checkbox"/>	<input type="checkbox"/>	
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Please list any drugs or medicines you are allergic to:
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Have you had any of the following?

	Yes	No		Yes	No
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Gastric reflux	<input type="checkbox"/>	<input type="checkbox"/>	(<input type="checkbox"/> high, <input type="checkbox"/> low)		
Cardiac pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice, Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to non-precious Metals (eg nickel in some jewellery)	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve disorder/	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Murmur/replacement	<input type="checkbox"/>	<input type="checkbox"/>	Do you Smoke	<input type="checkbox"/>	<input type="checkbox"/>

Have you possibly had any contact with HIV/AIDS virus? Yes No

Have you had any ill effects following any dental treatment? Yes No

Have you or any relative had any history of prolonged bleeding? Yes No

Have you had any serious problems after a dental extraction? Yes No

Do you tend to have any sinus problems? Yes No

Have you had any ill effects from an antibiotic?
Which type? Yes No

Have you had any ill effects from a local anaesthetic? Yes No

Do you regularly take Aspirin or other similar medications? Yes No

On exertion, do you have chest pains, shortness of breath?
or palpitations? Yes No

Ladies, are you or might you be pregnant? Yes No
Due when?.....

Any other medical condition?.....

I have completed this form to the best of my knowledge and acknowledge that this represents an accurate medical history.

Date..... Signature.....

(Parent or guardian if under 18 years)

Please read our Privacy Statement available at reception.

How did you find out about our practice?.....

Have you had any of the following?

	Yes	No
Does your jaw "click" or hurt?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel your grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear a dental night guard?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had periodontal (gum) treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had your bite adjusted?	<input type="checkbox"/>	<input type="checkbox"/>
Do you bite your lips or cheeks often?	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you have occasional bad breath?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums ever bleed when you clean your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience sensitivity with hot/cold?	<input type="checkbox"/>	<input type="checkbox"/>
Do your teeth ever hurt when you bite hard?	<input type="checkbox"/>	<input type="checkbox"/>
Does floss ever tear between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Does food ever get caught between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any other concerns you would like us to know about?	<input type="checkbox"/>	<input type="checkbox"/>

How long since your last dental appointment? _____

How often do you have dental examinations? _____

Previous dental x-rays were taken: Less than one year Longer than one year

The name of your physician _____

Address _____ Postcode _____

Phone Number _____

Consent for treatment

1. I hereby authorize the dentist or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.
2. Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient's signature:

Date:

Parent/Responsible Party's Signature:

Relationship to patient:

**(WE EXPECT AND APPRECIATE PAYMENT AT TIME OF SERVICE)WE ACCEPT
MASTERCARD, VISA, PERSONAL CHEQUE AND CASH.**