Medical and Dental History Form

Clear Choice Dental

We are pleased to welcome you to our practice.
Please answer the following questions as completely as possible.
This information is necessary to enable us to provide you with the best dental care.
All information disclosed is completely confidential.

Personal Details

First Name (Mr/Mrs/Miss/Ms/Dr)..... Surname.....

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

Date of Birth...../...../..... Phone (Home)..... Mobile.....

Occupation:.....Phone (work).....

Email.....

Nearest Relative.....Address.....
(Not on your address)

.....Telephone Relative.....

Person responsible for paying this account?.....

Which Private Health Fund do you belong to?.....

Whom may we thank for recommending you to our practice?.....

Health Details *Private & Confidential*

The state of your health may have a very significant effect on your dental care. Please answer these questions fully or discuss them with your dentist.

Are you receiving ANY medical treatment at present?.....

Name/details of your medical practitioner/specialist.....

Some medicines may interfere with your dental treatment or react with medicaments used by your dentist. It is important that your dentist knows precisely what medications you are taking.

Please list ANY medicine or medication that you are currently taking, or have been taking recently. Please include dose and frequency where possible.

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If you are in any doubt about your medication, please bring the bottle or packet(s) to the practice to show the dentist.

Do you smoke? ❒ Yes ❒ No If yes, for how long?.....How much do you smoke?.....per day.

Have you ever required any treatment for smoking related diseases or conditions? ❒ Yes ❒ No

Females Are you or could you be pregnant? ❒ Yes ❒ No if so, when are you due?.....

Are you breastfeeding? ❒ Yes ❒ No

Please turn over....

Phone: 9452 8877
www.clearchoicedental.com.au
Unit 3 / 1909 Albany Hwy Maddington 6109
Email:maddington@clearchoicedental.com.au

Do you have, or have you ever had any of the following?

	Yes	No
Allergies or reaction to any medicine *(eg: Penicillin, codeine, sulphur etc.)*	☐	☐
Allergies to other substances or chemicals *(eg: latex, antiseptics, chlorine etc.)*	☐	☐
Arthritis	☐	☐
Artificial joints *(eg: Hip, Knee replacement)*	☐	☐
Asthma/Lung conditions	☐	☐
Bisphosphonate Medication *(eg. Fosamax, Actonel, Zometa)*	☐	☐
Blood thinners *eg: (Warfarin, Aspirin)*	☐	☐
Blood disorders	☐	☐
Bone disorders *(eg: Osteoporosis, Pagets)*	☐	☐
Cancers or Tumors	☐	☐
Depression	☐	☐
Diabetes or family history of Diabetes	☐	☐
Fainting or dizziness	☐	☐

	Yes	No
Epilepsy or other Neurological disorder	☐	☐
Hepatitis B or C	☐	☐
HIV /AIDS	☐	☐
Heart problems (*eg: Heart attack, Angina, Stroke, Murmur)*	☐	☐
Heart Surgery (*eg. By-pass, Pacemaker, Valve replacement)*	☐	☐
High or Low Blood Pressure	☐	☐
Kidney or Liver disease	☐	☐
Osteoporosis or low bone density	☐	☐
Rheumatic Fever	☐	☐
Radiation or Chemotherapy	☐	☐
Sinus problems	☐	☐
Thyroid disease including Goitre	☐	☐
Transplanted organ or bone marrow	☐	☐
Refux (GORD)	☐	☐

Are you interested in a free dentofacial cosmetic consult? ☐ ☐

Dental History

What is the main reason for your visit today?.....

How long has it been since your last dental visit?.....

Previous dental x-rays were taken: ☐ Less than a year ago ☐ Longer than a year ago

Are you experiencing any of the following dental problems? (please tick as many as apply)

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Food trapping between your teeth
- ☐ Clicking pain in the jaw joints
- ☐ Broken teeth / fillings
- ☐ Sensitivity to hot /cold
- ☐ Discolouration of your teeth
- ☐ Issues with previous dental treatment
- ☐ Grinding and clenching your teeth
- ☐ Old mercury (amalgam fillings)
- ☐ Inability to chew
- ☐ Loose teeth
- ☐ Missing teeth
- ☐ Crooked teeth
- ☐ Pain on biting

How do you feel about having dental treatment?

☐ Extremely nervous ☐ Moderately nervous ☐ Mild case of nerves ☐ Relaxed

Declaration and Consent

In signing this form I acknowledge that this represents an accurate medical history. I hereby authorise the dentist or designated team member to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. I hereby consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated. I fully understand that using anaesthetic agents embodies certain risks. I agree to be responsible of payment of all services rendered on my behalf and on behalf of my dependants. I understand that payment is required on the day of treatment. 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 apply if I fail to do so.

..../...../.....

Patient Signature (Parent or guardian if under 18 years) Date of Signature