MYERS STREET
DENTAL CLINIC

NEW PATIENT MEDICAL & DENTAL HISTORY FORM

We are pleased to welcome you to our practice. Please complete the form. The following information is necessary to enable us to provide you with the best dental care. All information disclosed is confidential.

Personal details

Title: ……. First name: ……. Last name: ……

Address: ……

Tel: H …… W …… Mobile ……

Gender: M F (please circle) Date of birth: ……..

Medicare Number: ……. Health fund: ……...

Emergency contact

Emergency Contact Name: …… Relationship: ……

Emergency Contact Phone Number: ……

Health care details

Doctor's name: …… Doctor's Tel: ……..

Doctor's Practice: ……..

Confidential Medical History

Habits

How many times a day do you smoke tobacco products: …… Is your diet high in sugar/or high frequency……

How many times a day do you chew tobacco, pan, gutkha or supari……. Do you drink a lot of fizzy or acidic drinks……

How many units of alcohol do you consume per week……. Do you use recreational drugs.....

(Note: a unit of alcohol is a single measure of spirit, a glass of wine/aperitif, or a half pint of beer/lager)

If you replied Yes to anything above, please give details……

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Rheaumatic Fever:……YES / NO

Heart Murmur: ……...YES / NO

High Blood Pressure: ……...YES / NO

Angina: ……...YES / NO

Heart Surgery: ….……....YES / NO

Thrombosis: …….....YES / NO

Pacemaker fitted: …….....YES / NO

Other Heart Condition: ……...YES / NO

If you have answered Yes to any heart condition please give details: …….

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Hepatitis: ……YES / NO

Anaemia: ……YES / NO

H.I.V.: ……YES / NO

Sickle Cell: …….....YES / NO

Abnormal Blood Test: ……...YES / NO

Haemophilia: …….....YES / NO

Blood refused by transfusion Service: …....YES / NO

Other Blood Condition: ……..YES / NO

If you have answered Yes to any blood conditions please give details: ……..

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Bronchitis: ……YES / NO

Emphysema: …….....YES / NO

Cystic Fibrosis: ……..YES / NO

Pneumonia: …….....YES / NO

Pleurisy: ……YES / NO

Chest Surgery: …….....YES / NO

Asthma: ……YES / NO

Other Chest Condition: ……...YES / NO

If you answered Yes to any chest conditions please give details: ……

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Liver Disease: …….....YES / NO
Kidney Disease: ……YES / NO
Diabetes / Family with Diabetes: ……YES / NO
Epilepsy: ……YES / NO
Acid Reflux or Eating Disorder: ……..YES / NO
Hiatus Hernia: ……YES / NO
Bone or Joint Disease: ……..YES / NO
Artificial Joint: ……...YES / NO
Fainting Attacks or Blackouts: ……..YES / NO
Giddiness: …….....YES / NO
Any past serious Illness or Infectious Disease: ……YES / NO
Cancer: …….....YES / NO
If you have answered Yes to anything above, please give details: ……..
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Allergies

Penicillin: ……YES / NO
Latex Allergy: ……YES / NO
Hay Fever: ……...YES / NO
Medicine: ……..…YES / NO
Anti-tetanus Serum: ……YES / NO
Plants: ……YES / NO
Eczema: ……YES / NO
Food: …….....YES / NO
General Anaesthetic: ……YES / NO
Aspirin: …….....YES / NO
Local Anaesthetic: ……YES / NO
Other Allergy: ……YES / NO
If you answered Yes to anything above, please give details: ……..

Warnings

Are you or could you be pregnant: …..YES / NO
Do you have a problem being reclined: ……..YES / NO
Do you require Antibiotic Cover: ……YES / NO
Have you had any steroids in the last 2 years: ……YES / NO
Do you have bruising or persistent bleeding after injury, surgery, or tooth extraction: ……YES / NO
Do you carry a Warning Card: …….YES / NO
Are you currently having treatment from a doctor, hospital or clinic: ……YES / NO
Have you had treatment that required you to be hospitalized: ……YES / NO
Is there anything else your dentist should know: …….....YES / NO
If you answered Yes to any warnings above please give details: ……
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Medication

List and state for any prescribed medicines, tablets, ointments, injections or inhalers (inc. contraceptives and HRT) that you are taking: ……...
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NOTICE TO INSURED PATIENTS REGARDING DENTAL BENEFITS INSURANCE

Item numbers on our statement represent as accurately as possible the procedures performed, but in no way are they a claim on anyone other than the patient for whom they were performed. The eligibility of the patient, or the procedures, to attract refunds, and the rates of those refunds, are determined by the conditions of the patients Health Insurance Policy. We accept no responsibility, to either party, for any decision the Insurer may make regarding the refund monies to the patient.

CONSENT

- ☐ I have completed this questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place me at undue medical risk and it is my responsibility to inform this office of any changes in my medical status
- ☐ I understand that notes, radiographs or models relating to my treatment may be sent to other dental practitioners to aid in my treatment and I consent to this.
- ☐ I also give my permission for the practice to use the above contact details to send me appointment reminders, notices or correspondence.
- ☐ I understand that the practice requires at least 24 hour's notice if I need to cancel my scheduled appointment and that a cancellation fee of $50.00 or more could be incurred if I fail to do so.
- ☐ I am aware that payment is required on the day of treatment
- ☐ The information collected on this questionnaire will be used for the purpose of providing treatment to you. Personal information such as your name, address and health insurance details will be used for the purpose of addressing accounts to you, as well as processing payments and writing to you about any issues arising from or affecting your treatment.

Signed: ..... Date: ……..