HEALTH HISTORY

So we can ensure we are looking after your needs, please review and complete the following questionnaire. Please be assured that this information is maintained in accordance with State and Federal Privacy Legislation.

Title __ _____ Surname ______________________ First Name _____________ Preferred _____________

Date of Birth __________ Address ______________________________________ Post Code __________

Home Phone _________________ Work Phone ________________ Mobile _________________

Email ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Preferred Reminder Method (please tick) - Phone Home ☐ Phone Mobile ☐ Phone Work ☐ SMS Mobile ☐ Email ☐

Private Health Fund (If any) ___________________________ Member Number ______________________

Occupation /School _____________________ Purpose of today's visit _____________________________

Is another member of your family a patient at our practice? Yes ☐ No ☐

EMERGENCY CONTACT OR IF UNDER 18 YRS PARENT/GUARDIAN DETAILS

Name _______________________ Relationship ________________ Phone _______________________

Address ____

How did you find us?

Please let us know who we can thank for inviting you to our practice.

Personal Referral ______________________________ Staff Referral ____________________________

Yellow Pages ☐ Yellow Pages Online ☐ Google ☐ Our Website ☐ Passing by ☐

Other _______________

Have you had any of the following?

Heart problems ☐	High blood pressure ☐	Low blood pressure ☐	Artificial joints ☐
Rheumatic fever ☐	Circulatory problems ☐	Radiation treatment ☐	Excessive bleeding ☐
Excessive bruising ☐	Ulcers (stomach) ☐	Sinus trouble ☐	Diabetes ☐
Asthma ☐	Epilepsy ☐	Liver or Kidney problems ☐	Tumour (past or present) ☐
HIV / Aids ☐	Nervous disorders ☐	Hepatitis A B C D E	Pacemaker ☐

Allergies Anaesthetics ☐ Penicillin ☐ Medications ☐ Latex ☐

Please list any medications ____

Local Doctor's name / surgery name ____________________ Doctor's phone number _______________

Medicare number ☐☐☐☐☐☐☐☐☐☐ Position ☐

DENTAL HISTORY

How long ago was your last dental appointment?

6 months ☐ 1 year ☐ 2 years ☐ unsure ☐

What was done at this appointment? _____

Please tell us any dental concerns you currently have.

Tooth ache ☐	Rapidly decaying teeth ☐	Bad breath ☐	Worn/broken teeth ☐
Sensitive teeth ☐	Lost filling / cavity ☐	Dry mouth ☐	Pain in face or jaw joints ☐
Bleeding gums ☐	Grinding/clenching ☐	Missing teeth ☐	Sounds from joint ☐
Loose teeth ☐	Unsatisfactory denture ☐	Discoloured teeth ☐	Bad appearance of teeth ☐

Could you be pregnant Y / N Do you smoke Y / N

Tell us about your home care

What sort of brush do you use?

Manual Soft ☐ Medium ☐ Electric ☐

How often do you floss?

Never ☐ On occasion ☐ Weekly ☐ Daily ☐ After meals ☐

Do you use any other cleaning aids? _____

Is there anything else you would like us to know? _____

Consent for treatment

1. I hereby authorise the dentist or designated staff to take x-rays, study models, photographs, and or diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.

2. Upon such diagnosis, I authorise 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 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 and on behalf of my dependants. I understand that payment is due at the time of service unless other arrangements have been made prior to the appointment being performed.

Patient's Signature : _____ Date : _____

Parent/Responsible Party's Signature : _____ Relationship to patient : _____

(WE EXPECT AND APPRECIATE PAYMENT AT TIME OF SERVICE WE ACCEPT ALL MAJOR CREDIT CARDS, AMERICAN EXPRESS, EFTPOS AND CASH)