NEW LAMBTON
FAMILY DENTAL

Medical History & Dental Questionnaire

Patient information

Surname: ______________________________

Given name: ______________________________

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr

Date of birth ___/____/_____

Address: ______________________________

____

Postcode_____________

Home phone: ___________________________

Mobile: _______________________________

Email__________________________________

Parent / Guardian details (if under18)

Name: _________________________________

Address: _______________________________

Phone: ________________________________

Emergency contact person

Name: ________________________________

Phone: ________________________________

Health fund information

Fund name: ____________________________

Fund number: __________________________

Patient number: ________________________

Other

Medicare number: ______________________

Medicare series number: ________________

Veteran's affairs number: _______________

Smiles number: ________________________

Smiles exp date: ________________________

Other: ________________________________

Referral information – how did you find us?

☐ Internet ☐ Walking by ☐ Radio ☐ Yellow pages ☐ Local search

☐ Family/ Friend _____________________ ☐ Referral ___________________________

☐ Other ____

Consent for contacting General Medical Practitioner

I, the undersigned, give my Dental Practitioner at Family Dental Group, permission to contact my General Practitioner or Specialist, **if required**, in the course of my dental treatment, to obtain or discuss issues that are relevant to my health.

I understand that this will be done in accordance with the Privacy Act and will be confidential

Patient/parent/guardian signature: ________________________________ Date: _____________

GP name: ___________________________________ GP contact number_______________________

Medical history

Have you ever had, or do you suffer from, any of the following? Please ☑ those that apply:

☐ Arthritis	☐ Heart disease/murmur/stent	☐ Steroid therapy
☐ Asthma	☐ Hepatitis A/B/C	☐ Stomach issues
☐ Blood disease	☐ Immune disorder	☐ Stress disorders
☐ Blood pressure	☐ Joint replacement	☐ Stroke
☐ Bone disease/ Osteoporosis	☐ Kidney disease	☐ Thyroid disease
☐ Cancer	☐ Liver disease	☐ Tuberculosis
☐ Chemo/radiation therapy	☐ Lung disease	☐ Currently pregnant_______________Wks
☐ Cholesterol	☐ Pacemaker	☐ Currently breast feeding____________
☐ Diabetes	☐ Psychiatric condition	☐ Smoker_________________________
☐ Epilepsy	☐ Rheumatic fever	☐ Other___________________________
☐ Fainting disorder	☐ Sinus problems	

How do you rate your overall **General Health**? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Are you currently taking any pills, medications, or supplements? ☐ No ☐ Yes→_____________________________________

Do you have any allergies to antibiotics, medications, latex or other substances? ☐ No ☐ Yes→ ______________________

Dental History

If you are experiencing any of the following, please ☑ all that apply

☐ Sensitivity to hot or cold	☐ Pain on biting	☐ Missing teeth
☐Rough existing fillings	☐Bleeding gums	☐ Worn/broken teeth
☐ Lost fillings	☐ Discoloured fillings	☐ Bad breath
☐ Tooth ache	☐ Crooked teeth	☐ Grinding or clenching
☐ Tooth decay	☐ Gaps between teeth	☐ Food trapping between teeth
☐ Loose or ill-fitting dentures	☐ Loose teeth	☐ Staining of your teeth
☐ Dry mouth	☐ Clicking or pain in the jaw	☐ Ulcers/blisters/lumps
☐ Problems with previous dental treatment		☐Problem with existing crown or bridge

Are you attending for a specific problem today? ☐ No ☐ Yes→____

How long ago was your last dental visit? ☐ Never ☐ 6mths or less ☐ between 1-2 yr ☐ between 2-5 yr ☐ over 5 yr

Does dental treatment make you feel nervous? ☐ Never ☐ Slightly ☐ Moderately ☐ Extremely

Are you satisfied with the appearance of your teeth? ☐ Yes ☐No →____

Do you have any other comments that would help the dentist with your treatment?________________________________

Consent for service

∗ I, the undersigned to the best of my knowledge have provided accurate information relating to my health and if any changes are required I will notify the Dentist/Surgery as soon as is practicable.

∗ I consent to the performing of dental and surgical procedures agreed to be necessary or advised, and will assume responsibility for the fees associated with those procedures.

∗ I am aware that full payment is made on the day of treatment.

∗ This form will be electronically copied to your clinical record file and the original will be subsequently destroyed.

* I agree to receiving SMS appointment reminders and recall notifications.

Name ___________________________________ Signature ________________________ Date _________________