Medical / Dental History Form

Title: Dr / Mr / Mrs / Miss / Ms Name: _____

Date of Birth: ____ / ____ /_____ Your Occupation: _____

Home Address: _____

_____ State: _____ Postcode: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

E-mail address: _____@_____

Emergency Contact Name: _____ Phone: _____

Medical Doctors Name _____ Phone: _____

How did you hear about us? (please circle): Dentist Referral Internet Search Friend/Family Other

PLEASE CIRCLE AND PROVIDE DETAILS:

1. Are you receiving any medical treatment at present? YES / NO
   Details: _____
2. Are you currently seeing or have seen a specialist for any reason? YES/NO
   Details: _____
3. Have you been in hospital during the past two years? YES / NO
   Details: _____
4. Are you currently taking ANY medication including painkillers, aspirin or herbal supplements? YES / NO
   Details: _____
5. Are you allergic to any medication, tablets or antibiotics? YES / NO
   Details: _____
6. Have you had any prosthetic surgery? (e.g. heart valve, stents, knee or hip replacements) YES / NO
   Details: _____
7. Are you currently pregnant or breastfeeding? (Females Only) YES / NO
8. Do you smoke? YES / NO / Former
   How many per day? _____ How many years have you smoked? _____ When did you quit? _____
9. Do you drink alcohol? YES / NO Amount per day or week _____
10. Have you ever received/are you currently receiving treatment for cancer? YES / NO
    Details: _____

Please Turn Over

DO YOU HAVE OR EVER HAD, ANY OF THE FOLLOWING CONDITIONS?

Please circle YES or NO to each condition.

Heart condition	YES / NO	High blood pressure	YES / NO	Low blood pressure	YES / NO
Steroid therapy	YES / NO	Kidney disease	YES / NO	Prosthetic implant	YES / NO
Rheumatic fever	YES / NO	Excessive bleeding	YES / NO	Cardiac pacemaker	YES / NO
Epilepsy	YES / NO	Stroke	YES / NO	Digestive condition	YES / NO
Asthma	YES / NO	Cancer	YES / NO	Liver Conditions	YES / NO
Diabetes	YES / NO	Tuberculosis	YES / NO	Blood borne virus	YES / NO
Thyroid disease	YES / NO	Lung condition	YES / NO	Bone disease	YES / NO
Depression/Anxiety	YES / NO	Blood disease	YES / NO	Radio/Chemo therapy	YES / NO
Sinus trouble	YES / NO	Bisphosphonate meds	YES / NO	Arthritis	YES / NO
Hep A/B/C	YES / NO	HIV / AIDS	YES / NO	Do you take aspirin?	YES / NO

Please list any allergies you have (e.g. latex, gluten, penicillin, etc.): _____

Do you have any other medical conditions not listed here? _____

Dental History

1. When was your last dental examination carried out? _____
2. Have you previously been diagnosed or treated for gum disease? YES / NO
3. Are you currently experiencing pain, sensitivity or soreness in the mouth? YES / NO

   Details: _____
4. Are you nervous, anxious or ever had a bad experience at a dental visit? YES / NO

   Details: _____
5. Are you happy with the function and/ or appearance of your teeth? YES / NO

   Details: _____
6. Do you want to discuss or find out more about any of the following?

Please CIRCLE:

Replacement of Missing Teeth Cosmetic Appearance

Bad Breath Bleeding Gums Tooth Grinding/Clenching

Dentures Dental Implants Mobile or Loose Teeth

Declaration & Appointment Policy:

I, _____, acknowledge that the information given on this form is true and accurate to the best of my knowledge.

Patient / Parent / Guardian Signature: _____ Date: _____/_____/_____

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ *I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature _____ Date _____

Relationship to Patient: *

_____

_____

_____

Response Date: _____