GOLD COAST DENTAL & DENTURE CENTRE

Medical/ Dental History Form – Confidential

Title (circle) MR / MRS / MS / MISS / MASTER / DR / PROF

First Name _____ Surname: _____

Date of birth _____

Home Address_____

Suburb _____ Post Code _____

Home Phone number _____ Work Number _____

Mobile Number _____ Email Address _____

Name of Private Health Fund _____ DVA card number _____

Occupation _____

Emergency Contact Name _____ Phone Number _____

General Practitioner GP contact details _____

How did you hear of our practice (circle)

Website / Yellow pages book or online / Facebook / Friend – Name _____ / Advertisement

Do you have or ever had the following medical conditions (please tick box):

○ Heart Condition	○ Bleeding	○ Diabetes
○ HIV	○ Low blood pressure	○ High blood pressure
○ Artificial Joints	○ Hepatitis A/B/C	○ Rheumatic Fever
○ Osteoporosis	○ Epilepsy	○ Cancer
○ Chemotherapy	○ Sleep Apnea	○ Radiation
○ Asthma	○ Thyroid Problems	○ Infectious Disease
○ Heart Attack	○ Pacemaker	○ Surgery
○ Angina	○ Murmur	○ Bypass
○ Valve Problem	○	○
Female patients Are you pregnant? YES/ NO		

Are you taking (circle):

Warfarin (Coomadin / Marevan) **Plavix** (Iscover) **Aspirin** (Astrix / Cartia)

Are you taking **bisphosphate** medications, medications for osteoporosis, multiple myeloma, metastatic cancer or Paget's disease? **YES / NO** specify

_____

Do You **Smoke**? YES / NO If yes how many / day _____

Are you **allergic** to any of the following **Latex** / **Medications** / **Anaesthetic / Penicillin / _____**

What medications including natural remedies are you taking?

_____

Do you have any missing teeth? YES / NO Do you wear dentures? YES / NO

Would you like to know about implants? YES / NO

Would you like to know more about tooth straightening / orthodontics? YES / NO

Would you like to know about tooth whitening? YES / NO

Do you floss your teeth? YES / NO

Terms of Acceptance and Consent:

- All information on this form is considered confidential and is necessary to ensure that best treatment can be provided
- Any treatment required will be provided with the patient's informed consent after all risks associated with the treatment are outlined
- 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 services rendered unless other arrangements have been made. I understand that failure to do this will incur additional fees
- I agree to provide a minimum of 48 hours notice if I need to cancel or re-schedule an appointment
- I have accurately completed this pre-clinical questionnaire to the best of my knowledge and agree to terms of acceptance
- I consent to the use of any study models, x-rays, computer images and photographs at various dental seminars, lectures, publications that the dental practitioner may author
- We provide as a courtesy to our patients a preventative recall program to attend our practice every 6 months

Your / Guardian Signature _____ Date: ____ / _____/ _____

Staff Review _____ Signature _____