MAITLAND Dental Care

MEDICAL HISTORY FORM

Last Name ________________________________ Title ____ First Name ____

Preferred Name ________________________________ Date of Birth _____________________

Residential Address ________________________________ Postal Address ____________________________________

____ ____

Home Phone ________________________________ ☐ Work Phone ____ ☐

Mobile Phone ______________________________ ☐ (Please tick preferred phone contact)

Email address ___________________________________ Health Fund _________________________ I.R.N.. _____

Medicare No. ________________________ Expiry ___ / ___ I.R.N. ___ DVA Number ___________________________

Employer _____________________ ________________

Pension Card holder ○ Health Care Card holder ○ Seniors' Card holder ○

Emergency Contact ____________________ Phone _______________ Address _____________________________________

Medical Practitioner ____________________________ Address____

How did you hear about us? ____

Please list **all** medications including non prescription medications ____

____ ____

Do you have or have ever had any of the following?	Yes	No		Yes	No
Allergies or reactions to anything	○	○	Kidney or liver impairment	○	○
Local anaesthetic problems	○	○	Have you ever been prescribed Bisphosphonates?	○	○
Bleeding following procedures or poor healing	○	○	Psychiatric treatment	○	○
Heart attack	○	○	Cancer and/or tumour	○	○
High blood pressure	○	○	Chemo and/or radiation treatment	○	○
Prosthetic heart valve	○	○	Stroke and/or cerebrovascular event	○	○
Heart or cardiovascular system problems	○	○	Sinus trouble	○	○
Prosthetic joints	○	○	Thyroid trouble	○	○
Rheumatic fever	○	○	Pace maker	○	○
Hepatitis A, B or C	○	○	Asthma	○	○
Osteoporosis	○	○	Anaemia	○	○
Tuberculosis	○	○	Arthritis `	○	○
Diabetes	○	○	High risk category for HIV	○	○
Epilepsy	○	○	Are you pregnant? If yes, due date _______________	○	○
If you answered yes to any of the above, please give details			Other	○	○

____ ____

PTO

DENTAL HISTORY

Why did you come to the dentist today?____

Have you ever experienced pain in your jaw or joint (TMJ)? Yes ◯ No ◯

Describe your dental health____

When was your last dental visit?____

Have you ever had a problem with dental work? Yes ◯ No ◯

Are you currently in pain? Yes ◯ No ◯

Are you happy with the appearance of your smile?____

Do you have Nitrous Oxide (Happy Gas) during dental treatment Yes ◯ No ◯

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorise the dental staff to perform any necessary dental services with my informed consent that I may need during diagnoses and treatment.

Signature____**Date**______________________________

Thank you for taking the time to fill out this form. Our office is committed to meeting or exceeding the standards of infection control advocated by the Australian Dental Association.