



The Dental Surgery in Belconnen

Suite 119A, Level 1, opposite Commonwealth Bank
Westfield Shoppingtown, Belconnen 2617
PO Box 1105, Belconnen 2615

Medical History Form

Please review and complete the following questionnaire so that we can ensure we are looking after your needs

SURNAME: _____ (MR/MRS/MISS/MST/MS/DR): _____

FIRST NAME: _____ DATE OF BIRTH (DD/MM/YYYY): _____

ADDRESS: _____

POST CODE: _____ EMERGENCY CONTACT NAME & NUMBER: _____

HOME PHONE: _____ MOBILE PHONE: _____

WORK PHONE: _____ EMAIL: _____

OCCUPATION: _____ PERSON RESPONSIBLE FOR PAYMENT: _____

RECOMMENDED BY: _____

PURPOSE OF VISIT: _____

PRIVATE HEALTH INSURANCE: _____

ARE ANY OTHER MEMBERS OF YOUR FAMILY A PATIENT AT OUR SURGERY? _____

Have you had any of the following? Please CIRCLE Yes or No:

Heart Problems	Yes / No	Osteoporosis	Yes / No
High Blood Pressure	Yes / No	Allergies to Medications or Latex	Yes / No
Low Blood Pressure	Yes / No	Anemia or other Blood Disorders	Yes / No
Artificial Joints	Yes / No	Diabetes	Yes / No
Circulatory Problems	Yes / No	Asthma	Yes / No
Radiation Treatment	Yes / No	Hepatitis	Yes / No
Excessive Bleeding or Bruising	Yes / No	HIV	Yes / No
Stomach Ulcers	Yes / No	Epilepsy	Yes / No
Sinus Trouble	Yes / No	Liver or Kidney Problems	Yes / No
Tumor History	Yes / No	Other _____	

Are you currently taking any drugs or medications? Yes / No If 'yes', please list:

Are you currently taking any blood thinners like Clopidogrel, Warfarin, Pradaxa? Yes / No

Have you ever been prescribed or currently taking any bisphosphonate medication like Fosamax, Alendronate, Risedronate, Pamidronate, Zoledronic, Ibandronate, Clodronate, Tiludronate, Denosumab, Etidronate?

Please CIRCLE Yes or No:

Does your jaw "click" or hurt?	Yes / No
Do you feel that you grind or clench your teeth?	Yes / No
Have you ever had orthodontic treatment?	Yes / No
Do you wear a dental night guard?	Yes / No
Have you ever had periodontal (gum) treatment?	Yes / No
Have you ever had your bite adjusted?	Yes / No
Do you bite your lips or cheeks often?	Yes / No
Do you smoke?	Yes / No
Do you think you have occasional bad breath?	Yes / No
Do you experience sensitivity with hot/cold?	Yes / No
Do your gums ever bleed when you clean your teeth?	Yes / No
Do your teeth ever hurt when you bite hard?	Yes / No
Does floss ever tear between your teeth?	Yes / No
Does food ever get jammed in between your teeth?	Yes / No
Is there anything else you would like us to know?	Yes / No

Other notes:

Name of your General Practitioner: _____ Phone Number: _____

Ladies, are you pregnant? **Yes / No** If 'yes', when is the due date? _____

How long since your last dental appointment? _____

How often do you have dental examinations? _____

Were previous dental x-rays taken less than one year ago? **Yes / No**

Consent for Treatment

1. I hereby authorise the dentist or designated team to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis
2. Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed to 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 anaesthetics agents embodies certain risks. I understand I can ask for 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 dependents. I understand that payment is due at the time of service unless other arrangements have been made.
5. I authorise that this data may be reviewed by team members of the dental practice.

Patients Signature: _____ Date: _____

Parent/Responsible Party's Signature: _____

Relationship to Patient: _____

