Oral Square Dental Care

Medical History Form
CONFIDENTIAL

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other Date of Birth: _____/_____/_____ Gender: ☐ M ☐ F

Given name(s): _____ Surname: _____

Address: _____ Suburb: _____ Postcode: _____

Ph (home): _____ Ph (work): _____ Mobile: _____

Email: _____ Occupation: _____

Emergency contact name: _____ Relationship: _____ Ph: _____

Who is your medical practitioner? _____ Ph: _____

When was your last dental visit? _____

☐ ***I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist about this.***

How did you hear about us? ☐ Website ☐ Flyer ☐ Google ☐ Facebook ☐ Newspaper

☐ Word of Mouth / From Patient: _____ ☐ Other: _____

Are you in a Private Health Fund with Dental Cover? If so, which one: _____

	YES	NO
Are you taking any prescription or herbal medication or supplements?	☐	☐
Do you normally require antibiotic cover before dental treatment?	☐	☐
Have you had any abnormal reactions to local or general anaesthesia?	☐	☐
Do you smoke?	☐	☐
Are you or could you be pregnant? (Females only)	☐	☐
Are you being treated by a doctor at present?	☐	☐
Have you been hospitalised in the last 12 months?	☐	☐
Have you or anyone in your household returned from overseas travel in the last 10 days	☐	☐

List Medications

_____

_____

_____

_____

_____

_____

Please list all known **ALLERGIES** (including drugs, latex, foods & preservatives): _____

_____

Do you have now, or have you ever had, any of the following medical conditions? (Please tick any you have or had)

☐ Asthma
☐ Tuberculosis
☐ Bronchitis, emphysema or other lung diseases
☐ Thyroid disease
☐ Hepatitis or other liver disease
☐ Excessive bleeding
☐ Anaemia
☐ Leukaemia or other blood diseases
☐ Prosthetic implant e.g. artificial hip / knee
☐ Bone disease, including osteoporosis
☐ High blood pressure
☐ Low blood pressure
☐ Heart disorder/complaint
☐ Cardiac pacemaker
☐ Rheumatic fever
☐ Stomach or digestive condition
☐ Nervous or psychiatric condition
☐ Contact with blood-borne viruses
☐ Cholesterol
☐ Stroke
☐ Diabetes
☐ Epilepsy
☐ Cancer
☐ Steroid therapy
☐ Radiation therapy
☐ Kidney disease
☐ Arthritis
☐ HIV / AIDS

Any other condition(s) (please list) _____

I have read and accept the 'PRIVACY POLICY' on the reverse of this form.

Signature: _____ Date: _____/_____/_____

Name (Print): _____ ***(Parent / Guardian needs to sign if patient is under 18 years)***

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Additional Dental Questionnaire:

Are you currently experiencing pain or a specific dental problem? _____

Are you nervous, anxious or ever had bad experience at a dental visit? _____

Are you happy with the appearance of your teeth and smile? _____

Do you have bleeding gums or have you ever been diagnosed with or treated for gum disease? _____

How frequently do you brush your teeth? Once a day / Twice a day / Other_____

How frequently do you floss or use interdental brushes to clean between your teeth? _____

Would you like to discuss or find out more about any of the following:

☐ Replacement of missing teeth	☐ Cosmetic appearance	☐ Removal of wisdom teeth	☐ Crowns	☐ Veneers
☐ Teeth whitening	☐ Bleeding gums	☐ Teeth grinding / Clenching	☐ Bad breath	☐ Dentures
☐ Root canal treatment	☐ Replacement of silver (mercury) fillings		☐ Implants	☐ Orthodontics

We respect your privacy

In order to provide you with the highest standard of dental care, this practice is required to collect personal information from you. This information covers basic details such as your name, address and telephone number but it is also necessary for the dentist to obtain from you details regarding your general health and past medical or surgical events. Without this general health picture, the treating dentist is unable to plan your care properly.

Naturally, some of this information is of a personal nature and some of it might be regarded as 'sensitive' and not the sort of information that you would wish to be unnecessarily disclosed to others.

We value the need to safeguard this information and in accordance with the principles laid down in privacy legislation and the guidelines issued by the Australian Dental Association, we would like to assure you that:

- This information will only be used by the treating dentist to deliver your care to the highest standards.
- It will not be disclosed to those not associated with your treatment without your consent except as provided under the legislation and where we consider you would have a reasonable expectation of us to provide such information.
- You may seek access to the information held about you and we will provide this access without undue delay. This access might be by inspection of your dental records at the time of appointment or by special access or copying of information at other times.
- There will be no charge made for requesting this information but there may be fees levied just to cover the cost associated with the processing of this request or the copying of information.
- We will take reasonable steps to ensure at all times that the details we keep about you are accurate, complete and up-to-date.
- We will take reasonable steps to protect this information from misuse or loss and from unauthorised access modification or disclosure.
- Our staff is trained to respect these principles at all times.

Office Use Only

Reviewed by: _____ Signature: _____ Date: _____