Registration, Medical & Dental History

Title: ________ Surname: ____

Given Name(s): ____

I Prefer to Be Called: ____________________ Date of Birth: ___ / ___ / ___

Marital Status: ☐ Single ☐ Married/Defacto Partner's Name: ______________________________

Residential Address: ____

Suburb: _________________________ Post Code: _________ Home Phone: _________________________

Occupation: ____________________________ Employer: ____________________________

Business Address: ____

Suburb: _________________________ Post Code: _________ Work Phone: _________________________

E-Mail: ____ Mobile Phone: _________________________

Additional Contact: Closest Relative, not living with you:

Name: ______________________________________ Phone No: ____________________________

How did you come to be referred to our Practice?

☐ Personal Referral – If so, by whom? ____

☐ Yellow Pages ☐ Internet ☐ Other: ________________________________

Do you have Private Dental Health Insurance? ☐ Yes ☐ No If so, with whom? ____________________

Please note: We provide a HiCaps facility for electronic claims direct from your funds! Please bring your health fund card to all appointments.

How would you prefer to be confirmed for future appointments? ☐ SMS ☐ e-mail ☐ phone call

Confidential Medical History

The thoroughness of this medical history is designed for your safety. Your complete and honest answers will assist us in treating you with consideration for your individual needs.

The name of your Doctor/Healthcare provider: ____________________________________

Are you currently receiving medical attention? ☐ Yes ☐ No If so, for what reason? ____________

____

Are you currently taking any medication? ☐ Yes ☐ No If so, please list: ________________

____

Have you had a medical examination in the past 12 months? ☐ Yes ☐ No If so, for what reason?

____

Do you or have you ever suffered from any of the following?

Condition	Y	N	Condition	Y	N	Condition	Y	N
Anaemia	Y	N	Hepatitis / Jaundice / HIV	Y	N	Osteoporosis	Y	N
Anxiety / Depression	Y	N	Heart Problems	Y	N	Prosthetic Joint(s)	Y	N
Arthritis	Y	N	Heart Attack / Angina	Y	N	Rheumatic Fever	Y	N
Asthma	Y	N	Heart Murmur	Y	N	Tumour History	Y	N
Bleeding Disorders	Y	N	Heart Valve (prosthetic)	Y	N	Radiation Therapy	Y	N
Blood Pressure (High)	Y	N	Cardiac Pacemaker	Y	N	Chemo-Therapy	Y	N
Bone Disorders	Y	N	Kidney Disease	Y	N	Sinus Problems	Y	N
Diabetes	Y	N	Liver Disease	Y	N	Tuberculosis	Y	N
Auto-Immune Disorder	Y	N	Neuro-Muscular Disorder	Y	N	Currently taking Antibiotics	Y	N

Do you have allergies to any of the following?

Penicillin Y N Latex Y N Local Anaesthetic Y N Other Medications: Y N

Please list: ____

Do you smoke? ☐ Yes ☐ No If so, how many packs per week? ________________________

Are you pregnant? ☐ Yes ☐ No ☐ Maybe? ☐ Not Applicable

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Confidential Dental History

Your answers to this dental history will help us understand your particular dental circumstances, so that we may more effectively treat you with consideration for your individual needs.

Name of your previous dentist: ____

Date of your last dental examination: ___ /___ /____ Were x-rays taken then? ☐ Yes ☐ No

Why did you leave that practice? ____

How often do you visit the dentist? ____

What is your immediate dental concern? ____

____

Have you had trouble with previous dental experiences?	☐ Yes	☐ No
Are you frustrated by the need for constant dental “repairs”?	☐ Yes	☐ No
Are you experiencing any pain or discomfort at present?	☐ Yes	☐ No

☐ Teeth ☐ Gums ☐ Jaws ☐ Face ☐ Head/Neck

Do you have sensitivity or discomfort with any of the following?	☐ Yes	☐ No

☐ Hot ☐ Cold ☐ Sweet ☐ Biting/Chewing

Do your gums look and feel healthy?	☐ Yes	☐ No
Do your gums bleed when you brush or floss?	☐ Yes	☐ No
Do you (or others) feel that you suffer from bad breath?	☐ Yes	☐ No
Have you previously had gum health problems?	☐ Yes	☐ No
Have members of your family had gum health problems?	☐ Yes	☐ No

How often do you brush your teeth?	☐ Twice+ per day	☐ Daily	☐ Infrequently	☐ Never
How often do you floss your teeth?	☐ Daily	☐ Weekly+	☐ Infrequently	☐ Never

Do you suffer from chronic or frequent:	Headaches	☐ Yes	☐ No
	Jaw Pain or Earache	☐ Yes	☐ No
	Neck/Shoulder Pain	☐ Yes	☐ No

Do you feel that you grind or clench your teeth?	☐ Yes	☐ No
Do you feel that your teeth have worn down?	☐ Yes	☐ No
Do you currently wear a “Nightguard” or “Splint”?	☐ Yes	☐ No
Do you suffer from Snoring or Sleep Apnoea?	☐ Yes	☐ No

Dento-Facial Aesthetics

Are you happy with:	Your smile?	☐ Yes	☐ No
	The appearance of your teeth?	☐ Yes	☐ No
	The shape of your teeth?	☐ Yes	☐ No
	The colour of your teeth?	☐ Yes	☐ No
	The alignment of your teeth?	☐ Yes	☐ No

Have you ever had:	Orthodontic Treatment?	☐ Yes	☐ No
	Tooth Whitening Treatment?	☐ Yes	☐ No

Have you ever had:	Facial Aesthetic Treatment?	☐ Yes	☐ No
	BOTOX® or DYSPORT®?	☐ Yes	☐ No
	Dermal Fillers?	☐ Yes	☐ No
	Other? ………………………	☐ Yes	☐ No

Would you like a free Facial Aesthetics consultation during your appointment today? Yes No

Thankyou for taking the time to complete this questionnaire!