ART DE DENTE

COSMETIC AND GENERAL DENTISTRY

NEW PATIENT MEDICAL & DENTAL HISTORY FORM

Please note that all information on this medical/dental form will remain strictly confidential.
Please complete in CAPITAL LETTERS Please print

PATIENT INFORMATION

Surname:	Given Names:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Birth date: / /

Occupation:	Phone: (W)	Phone: (M)	Phone: (H)	Preferred contact:

Home address:	Email address:	Emergency Contact:

Health Fund:	Member Number:	Are you under 18 years of age? ❑ Yes ❑ No

If Yes, what is your guardian's Name?	Guardian's Address:	Guardian's Phone Details: ( )

Would you like your next 6 monthly reminder to be sent via... ❑ Post ❑ Email ❑ SMS

REFERRAL INFORMATION

❑ Internet / Website	❑ Walk in	❑ Yellow Pages	❑ City Weekly	❑ Patient Patient's Name:	Other:

MEDICAL HISTORY

Name of your GP:	Your Doctor's Address:	Your Doctor's Phone No. ( )

Have you ever had any of the following? Please tick those that apply:

❑ Anemia	❑ Fainting	❑ Pacemaker
❑ Artificial Joints	❑ Glaucoma	❑ Radiation Therapy
❑ Asthma	❑ Heart Disease	❑ Respiratory Problems
❑ Blood Disease	❑ Heart Murmur	❑ Rheumatic Fever
❑ Cancer	❑ Hepatitis A, B, C	❑ Sinus Problems
❑ Dizziness	❑ Jaundice	❑ Stroke
❑ Epilepsy	❑ Kidney Disease	❑ Tuberculosis
❑ Excessive Bleeding	❑ Liver Disease	❑ Tumors
❑ Diabetes	❑ HIV	❑ Psychological Disorders

Are you pregnant? ❑ Yes ❑ No	If yes, how many months?
Have you had any serious illnesses in the last 2 years? If yes, please provide more information.	
Are you currently taking any medications or tablets regularly? If yes, please provide more information.	
Do you have allergies to Penicillin or other drugs? If yes, please provide more information.	

Do you suffer from sleep apnea?	
Is your blood pressure normal, high or low?	
Do you smoke? If so, how many per day?	

DENTAL HISTORY

Are you concerned about or experiencing any of the following dental problems? (Please tick as many as it applies)

❑ Sensitivity to hot or cold ❑ Staining of your teeth ❑ Bleeding gums ❑ Head/neck ache	❑ Food trapping between your teeth ❑ Discolored fillings ❑ Bad breath ❑ Grinding or clenching of your teeth	❑ Clicking/pain in the jaw joints ❑ Roughness of existing fillings ❑ Sensitivity when eating

Are you concerned with: (Please tick as many as it applies)

❑ Existing crowns, bridges or dentures ❑ Tooth clean techniques ❑ Crooked / Missing teeth	❑ Ability to eat ❑ Your smile ❑ Silver fillings	❑ Gaps between your teeth ❑ Discoloration of your teeth ❑ Previous dental treatment

What is the main purpose of your visit today?	
How long since your last dental visit?	

Does dental treatment make you nervous?

❑ No	❑ Slightly	❑ Moderately	❑ Extremely

Have you ever had or require the following for dental treatment?

❑ Gas (Nitrous oxide-laughing gas)	❑ Intravenous sedation	❑ General Anesthesia

CONSENT FOR SERVICES

- I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated and I will assume responsibility to the fees associated with those procedures.
- I understand that the practice requires at least 24 hours notice if I need to cancel my scheduled appointment and that a cancellation fee of $50.00 could be incurred if I fail to do so.
- I hereby consent to the use of any study models, x-rays, computer images and photographs at various dental seminars, lectures, and publications that the dentists may author.
- I am aware that payment is required on the day of treatment.

x ______________________________ x ______________________________

Patient/Guardian signature *Date of signature*