Golden Grove Dental Service - Medical and Dental History

Welcome to our dental practice. It is important to know details about your medical history in order to provide you with dental treatment of the highest calibre. Please note that all information on this medical history form will remain strictly confidential. Please complete all sections in CAPITAL LETTERS and provide details where applicable.

PATIENT DETAILS			
Title		Patient ID Number (office use only)	
Given Names		Preferred Name	
Surname		Date of Birth	
Occupation		Employer	
Phone (H) □ (W) □ (M) □ **please tick which contact number you would prefer*		Postal Address	
Email	**please note that all documents and/or reciepts will be emailed, NOT posted.*		
Health fund		Member Number	Series
Person responsible for the account:			

EMERGENCY CONTACT/PARENT/GUARDIAN	
Name	
Phone Number	
Relationship	

MEDICAL HISTORY					
Name of your Doctor:			Phone Number:		
Have you ever had or are you suffering from any of the following? ***Please circle and provide details.***					
Asthma	Y / N	Abnormal Bleeding	Y / N	Rheumatic Fever	Y / N
Fainting Disorder	Y / N	Blood Disorders	Y / N	Kidney/Liver Disease	Y / N
Shortness of Breath	Y / N	Anaemia	Y / N	HIV or AIDS	Y / N
Chronic Pain	Y / N	Blood Transfusion	Y / N	Steroid Therapy	Y / N
Diabetes	Y / N	Sleep Apnoea	Y / N	Radiation Therapy	Y / N
High or Low Blood Pressure	Y / N	Epilepsy	Y / N	Artificial Joint Replacement	Y / N
Heart Condition	Y / N	Osteoporosis	Y / N	Cardiac Pacemaker	Y / N
Arthritis	Y / N	Stroke	Y / N	Organ Transplant	Y / N
Stomach or Digestive Condition	Y / N	Cancer	Y / N	Allergy to Latex	Y / N
Nervous or Mental Condition	Y / N	Hepatitis A, B or C	Y / N	Allergy to Medications	Y / N
Lung Condition	Y / N	Thyroid Disease	Y / N	Other Allergies (please specify)	Y / N

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Please list any other conditions and/or allergies not listed:				
Are you of Aboriginal and/or Torres Strait Islander descent?				Y / N
Have you been hospitalised during the past 2 years? *Please provide details.*				Y / N
Are you taking any prescription or non-prescription medications? *Please provide details.*				Y / N
Do you smoke?	Y / N	How many per day?		
For Women	Are you pregnant	Y / N	Nursing	Y / N

DENTAL HISTORY					
Are you concerned about any of the following dental problems?					
Sensitivity to Hot/Cold	Y / N	Food Trapping Between Teeth	Y / N	Clicking/Pain in Jaw Joints	Y / N
Staining of Teeth/Fillings	Y / N	Appearance of Teeth	Y / N	Roughness of Existing Fillings	Y / N
Bleeding Gums	Y / N	Bad Breath	Y / N	Sensitivity When Eating	Y / N
Head/Neck Pain	Y / N	Clenching/Grinding of Teeth	Y / N	Existing Crowns/Bridge/Denture	Y / N
Are you happy with your smile?					
What is the main purpose of today's visit?					
How long since your last dental visit?					

REFERRAL INFORMATION		
□ Internet/Website	□ Walk By	□ Yellow Pages
□ Family/Friend. Name:	□ Attend Medical Practice	□ Other:

CONSENT FOR SERVICES
I, the undersigned, consent to the performing of dental procedures, as discussed between myself and the dental practitioner, including the use of local anaesthetic and other medication as indicated and I will assume responsibility for the fees associated with those procedures (unless otherwise specified).
I understand that the practice requires at least 24hours notice if I need to cancel my scheduled appointments and that a cancellation fee may be incurred if I fail to do so.
With my consent, I authorize 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.

Patient/Parent/Guardian: _____ ***Date:*** _____