Health History Form

So we can ensure that we provide you with the best possible care,
please answer all questions

DENTAL HISTORY

Please tick yes or no if you have had any of the following conditions

	YES	NO
Have you had a bad experience at the dentist?	☐	☐
Does your jaw click or hurt?	☐	☐
Do you feel you grind your teeth?	☐	☐
Have you ever had orthodontic treatment?	☐	☐
Do you wear a night guard?	☐	☐
Have you ever had periodontal (gum) treatment?	☐	☐
Do your gums bleed when you clean your teeth?	☐	☐
Do you think you have bad breath?	☐	☐
Do you ever experience sensitivity to hot/cold?	☐	☐
Do your teeth ever hurt when you bite hard?	☐	☐
Does floss ever tear between your teeth?	☐	☐
Does food get jammed between your teeth?	☐	☐
Is there any other concerns about your teeth?	☐	☐

If yes please give details

Are you interested in any cosmetic procedures for your teeth? Yes ☐ No ☐

If yes, which procedures would you be interested in?

How long since your last dental appointment?

How often do you have dental examinations?

Have you had any dental x-rays in the past year?

PREFERRED REMINDER METHOD

What is your preferred method, when confirming your appointments?

Telephone ☐

SMS ☐

Email ☐

PRIVACY & CONFIDENTIAL INFORMATION

☐ I have confidential medical information that I do not wish to write down. I would prefer to speak with the dentist about this. [tick box]

I have been offered the Privacy Policy to read for this practice. I acknowledge that I have read it and understand the policy.
[Please tick yes or no] Yes ☐ No ☐

CONSENT FOR TREATMENT

1. I hereby authorise the dentist or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis as mutually agreed upon by me.

2. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide the appropriate care.

3. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents and embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf and/or on behalf of my dependants. I understand that payment is due at any time of service unless other arrangements have been made.

Patient's Signature | Date

Parent/Guardian Signature
[if under 18 years old] | Relationship to patient

PAYMENT FOR TREATMENT

We expect and appreciate payment at the time of treatment. We accept Eftpos, Visa, Mastercard, Amex, personal cheque and cash.

We also can process your private health fund claim at the time of your appointment. However we do need your card at every visit.

CANCELLATION POLICY

We have a 48 hour (2 business days) cancellation policy to allow us ample time to offer your appointment to another patient in need of it.

A fee may be charged for missed appointments or failure to reschedule before the 48 hour (2 business days) time frame.

I understand the payment and cancellation policies for Absolute Dental Care.

Patient's Signature | Date

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PATIENT CONTACT DETAILS

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other ☐

Surname

Given Name/s

Preferred Name

Gender

Date of Birth

Occupation

Mailing Address

Postcode

Email Address

Home Phone

Mobile Phone

Work Phone

Health Fund Name

WELCOME TO OUR PRACTICE

How did you hear about our practice?

Who can we thank for referring you to our practice?

INCASE OF EMERGENCY

Name of next of kin

Telephone

General Practitioner

Telephone

Name of Medical Centre

Are you being treated by your GP or a specialist at the moment? Yes ☐ No ☐
If yes, please give details:

MEDICAL HISTORY

Please tick yes or no if you have had any of the following conditions

Condition	Yes	No
Blood Pressure: High or Low (please circle)	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐
Artificial Joints	Yes ☐	No ☐
Rheumatic Fever	Yes ☐	No ☐
Circulatory Problems	Yes ☐	No ☐
Radiation Treatment	Yes ☐	No ☐
Excessive Bleeding	Yes ☐	No ☐
Excessive Bruising	Yes ☐	No ☐
Kidney Disease	Yes ☐	No ☐
Ulcers [stomach]	Yes ☐	No ☐
Sinus Trouble	Yes ☐	No ☐
Cancer/Tumour History	Yes ☐	No ☐
Anaemia or other blood Disorders	Yes ☐	No ☐
Diabetes: Type 1 or 2	Yes ☐	No ☐
Asthma	Yes ☐	No ☐
Hepatitis: A B C	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐
Liver or Kidney Disease	Yes ☐	No ☐
Contact with HIV/AIDS virus	Yes ☐	No ☐
Steroid Therapy	Yes ☐	No ☐
Bone Disease including Osteoporosis	Yes ☐	No ☐
Ladies, are you pregnant?	Yes ☐	No ☐
Do you have any heart conditions?	Yes ☐	No ☐

If yes, please give details

Has your GP or specialist told you that you require antibiotic cover before dental treatment?

ALLERGIES

Do you have any adverse reactions and/or allergies to any drugs or medications? Yes ☐ No ☐
If yes, please give details

Allergies to Anaesthetics Yes ☐ No ☐

Allergies to Latex Yes ☐ No ☐

MEDICATIONS, DRUGS & VITAMINS

Are you taking any drugs, medications [including vitamins & herb supplements]?
If yes, please give details [If list is long please attach to this form]

Do you or have you ever smoked? [If yes, how many and how many years]

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