Carrum Downs FAMILY DENTAL

HEALTH HISTORY FORM

Dr/Mr/Mrs/Miss/Ms First Name(s): _____ Surname _____

Address: _____ Suburb: _____ Postcode: _____

Date of Birth: _____ Tel (Home): _____ Tel (Mobile): _____

Email: _____ Occupation: _____

Contact in case of emergency: _____ Relationship: _____ Tel: _____

Are you in a Private Health Fund? Yes / No Fund Name: _____

Member No: _____ Reference on Card (# next to name): _____

How did you find us? (e.g. google, letter drop, referral etc) _____

If referred, who referred you? _____

DENTAL HISTORY

What is the purpose of your visit? _____

Do you have any specific concerns? _____

When was your last dental examination? _____

Are you happy with the appearance of your teeth? _____

Have you had any previous problems with dental treatment? _____

Are you concerned with crowding or crooked teeth? _____

Do you have any issues sleeping, tiredness or snoring? _____

Do you have any history of sleep apnoea or CPAP use? _____

MEDICAL HISTORY

Name of Medical GP: _____ Clinic: _____

Are you taking any Medications presently: (if yes, please list): _____

_____

_____

Do you have any Allergies: (e.g. Penicillin, Latex, Codeine) (if yes please list): _____

_____

Please indicate below if you have had, or have at present, any of the following: *(please tick)*

- ❑ High Blood Pressure
- ❑ Heart Ailment
- ❑ Rheumatic Fever
- ❑ Asthma, Chest or Breathing Problems
- ❑ Tuberculosis
- ❑ Stomach or Bowel Problems
- ❑ Kidney Disease
- ❑ Prosthetic Valves/Hip/Implants
- ❑ Diabetes
- ❑ Thyroid Problems
- ❑ Excessive Bleeding or Blood Disorders
- ❑ Epilepsy
- ❑ Hepatitis
- ❑ AIDS/HIV
- ❑ Bone Disorders or Diseases
- ❑ Radiation or Chemotherapy

Do you smoke: Yes / No

Females only Are You Pregnant: Yes / No Are You Nursing: Yes / No

Other (please describe): _____

I understand that all treatment is to be paid for on the day of treatment as no credit is given. I understand that notes, radiographs (x-rays) or models related to treatment may be sent to other dental practioners to aid in treatment and consent to this. I also give permission for the practice to use the above contact details to send me appointment and check-up reminders.

Name: _____ Signature: _____ Date: _____

Patient / Parent / Guardian **(please circle)**