Dental Lounge

Medical & dental history form

Patient details

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Other: _____ Surname: _____

Given name: _____ Preffered name: _____ D.O.B: ____ / ____ / ____

Residential address: _____

Suburb: _____ Postcode: _____ State: _____

Home phone: _____ Work phone: _____ Mobile: _____

Email: _____

☐ We will send you email communications from time to time, including our regular newsletter and offers. Please tick this box if you don't wish to receive communication from us.

Occupation: _____ Company: _____

Company address: _____

Private health insurer: _____ Member #: _____ Patient #: _____

Emergency contact: _____ Phone: _____ Relation: _____

Preferred method of communication

☐ SMS ☐ Telephone ☐ Email

Medical history

☐ Abnormal bleeding
☐ Angina
☐ Artificial heart valve
☐ Asthma
☐ Bone disease
☐ High/low blood pressure
☐ Blood thinner
☐ Cardiac surgery/pacemaker
☐ Congenital heart defect
☐ Diabetes type 1/type 2
☐ Epilepsy
☐ Heart murmur
☐ Hepatitis A/B/C/D
☐ HIV positive
☐ Kidney/liver disease
☐ MS
☐ Nervous disorder
☐ Oral cancer
☐ Pregnant
☐ Prosthetic hip
☐ Radiation/chemotherapy
☐ Reflux
☐ Rheumatic fever
☐ Sleep apnoea
☐ Steroid therapy
☐ Stroke
☐ Thyroid disorder

Are you taking medication? If yes, please list: _____

Are you a smoker? If yes, how often? _____

Do you snore regularly, and does it disturb others sleeping close by? _____

Do you wake unrefreshed, and can you be sleepy during the day? _____

Has anyone observed any disturbances to your breathing while asleep? _____

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Dental allergies

☐ Penicillin ☐ Aspirin ☐ Iodine ☐ Sulpha drugs ☐ Latex

Other (please specify): _____

Dental history

Last dental visit: ____ / ____ / ____

Have you ever had any reaction or complication following dental treatment in the past? If yes, please detail: _____

_____

Is there anything else the dentist or hygienist should be aware of? _____

Are you suffering from any of the following?

☐ Toothache
☐ Sensitive teeth
☐ Bleeding tums
☐ Loose teeth
☐ Bad breath
☐ Dry mouth
☐ Missing teeth
☐ Unsatisfactory denture
☐ Rapidly decaying teeth
☐ Lost filling/cavity
☐ Grinding/clenching teeth
☐ Worn or broken teeth
☐ Pain in face/jaw
☐ Sounds from joint
☐ Difficulty chewing
☐ Discoloured teeth
☐ Bad appearance of teeth

Have you ever had a sleep study and been diagnosed with sleep apnoea? ☐ Yes ☐ No

If yes, have you ever tried Continuous Positive Airway Pressure (CPAP) therapy? ☐ Yes ☐ No

How did you find out about us?

☐ Walk in
☐ Friend/ family (please specify)
Name: _____
☐ Bupa
☐ Digital radio
☐ 2GB
☐ Local Business Referral
☐ Google
☐ Health engine
☐ Facebook
☐ Instagram
☐ LinkedIn
☐ Promotion
☐ TV
☐ Hunters Hill
☐ Staff
☐ Dental Care Network

On a scale of 1 – 10 how comfortable are you feeling about your appointment today?

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

Privacy policy & signature

Any information is collected and maintained in accordance with State and Federal Privacy Legislation. A copy of our privacy policy can be obtained at reception.

I have accurately completed this medical history form to the best of my knowledge. I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentists and their staff.

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

I authorise my dentist to take images of my teeth both before and after my treatment. I understand these images may be used in a practice portfolio to showcase examples of dental work to other patients and my identity will remain anonymous.

Patient name: _____ Signature: _____ Date: ____ / ____ / ____

I understand that payment is required on the day of treatment and appointments exceeding 1 hour may require a deposit. I understand that failure to provide 48hrs notice incurs a cancellation fee of $50 and forfeit any deposits held by Dental Lounge.