MEDICAL HISTORY FORM

Paul A Trembath BDSc Qld

Central Chamber
1407 Logan Rd
Mt Gravatt Q 4122

Welcome to our practice!

Please complete this Medical Questionnaire.
All questions are relevant to modern dental practice. All information is strictly confidential.

Surname:…………………..….. First name……………………..…… Mr/Mrs/Ms/Miss Date of birth…../…../…..

Address……………………………………………………………...Suburb……………………...Postcode……….

Phone (H)……………………. (W)…………………… (M)……………………………

Occupation……………………… Email ....…………………........……………………

Ethnical Background ………………………………Country of Birth …………………..………………………

We like to give our patients a courtesy reminder message before appointments.
Please let us know if you do not want a reminder sent via SMS.

Do you have Private Health Insurance for Dental? Y / N Name of fund…………........………

Are you a Veteran Affairs Gold Card holder? Y / N

Who can we contact IN CASE OF EMERGENCY: Name……………………………………..….

Telephone…………………………Relationship to you ....

How did you hear about Paul Trembath Dental?

Internet search using ☐ Google ☐ Bing ☐Yahoo

Please tick any Key words you used to find us
☐ Mt Gravatt ☐ Brisbane ☐ South Brisbane ☐ Dentist ☐ Dentistry ☐Tooth whitening ☐ Cosmetics
☐ Implants ☐ Fillings ☐ Paul Trembath ☐ Other key words(Please list)...

☐ **Word of mouth: ....** (please write referrers name as we like to send a thank you voucher)
☐ **Phone Book** ☐ **Yellow Page online** ☐ **Walking/driving past** ☐ **Other**............................

I would like some information on

☐ Smile Makeover **☐ Cosmetic Solutions** **☐ Tooth Whitening**
☐ Implants **☐ Crown/Bridge** **☐ Veneers**
☐ Root Canal Treatment **☐ Dry Mouth Solutions** **☐ Bad Breath Solutions**
☐ Gum Disease Prevention **☐ Dentures**

MEDICATION LIST AND ALLERGY ASSESSMENT

Please list all medication including prescription, over the counter and vitamins:

………

………

………

Do you suffer from any significant chronic illness? Y/N List details...
Have you been hospitalised due to illness? Y/N details ....……………………..........………………
Do you normally require Antibiotic Cover before dental treatment? Y/N
(for Heart Valve disorder or Prosthetic Joints etc)

Please list any allergies you have, symptoms and treatment:

Allergy	Symptoms	Treatment
………………………	…………………………	………………………………………………..
………………………	…………………………	………………………………………………..
………………………	…………………………	………………………………………………..

Have you had any of the following?

	Yes	No		Yes	No
Rheumatic fever	☐	☐	Blood Pressure	☐	☐
Gastric reflux	☐	☐	(☐ high, ☐ low)		
Cardiac pacemaker	☐	☐	Jaundice, Hepatitis	☐	☐
Anaemia	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Allergy to non-precious	☐	☐
Osteoporosis	☐	☐	Metals (e.g. nickel in some jewellery)		
Epilepsy	☐	☐	Asthma	☐	☐
Heart valve disorder/	☐	☐	Tuberculosis	☐	☐
Murmur/replacement	☐	☐	Do you Smoke	☐	☐

	Yes	No
Have you possibly had any contact with HIV/AIDS virus?	☐	☐
Have you had any ill effects following any dental treatment?	☐	☐
Have you or any relative had any history of prolonged bleeding?	☐	☐
Have you had any serious problems after a dental extraction?	☐	☐
Do you tend to have any sinus problems?	☐	☐
Have you had any ill effects from an antibiotic? Which type/s?....................................	☐	☐
Have you had any ill effects from a local anaesthetic?	☐	☐
Do you regularly take blood thinners or other similar medications?	☐	☐
On exertion, do you have chest pains, shortness of breath or palpitations?	☐	☐
Ladies, are you or might you be pregnant? Due date?……………………	☐	☐

List any other medical conditions? ____

☐ ***I have confidential medical information that I do not wish to write down. I would prefer to speak to the dentist about this.***

I have completed this form to the best of my knowledge and acknowledge that this represents an accurate medical history.

Signature……………………………………………….. Name……………………….. Date………………..

Have you had any of the following?

	Yes	No
Does your jaw "click" or hurt?	☐	☐
Do you feel you grind your teeth?	☐	☐
Have you ever had orthodontic treatment?	☐	☐
Do you wear a dental night guard?	☐	☐
Have you ever had periodontal (gum) treatment?	☐	☐
Have you ever had your bite adjusted?	☐	☐
Do you bite your lips or cheeks often?	☐	☐
Do you think you have occasional bad breath?	☐	☐
Do your gums ever bleed when you clean your teeth?	☐	☐
Do you experience sensitivity with hot/cold?	☐	☐
Do your teeth ever hurt when you bite hard?	☐	☐
Does floss ever tear between your teeth?	☐	☐
Does food ever get caught between your teeth?	☐	☐
Are there any other concerns you would like us to know about?	☐	☐

How long since your last dental appointment? ___________________

How often do you have dental examinations? ________________________

Previous dental x-rays were taken: Less than one year ☐ Longer than one year ☐

The name of your physician (Doctor)__________________________________

Address__________________________________ Postcode________

Phone Number__________________

Consent for treatment

1. I hereby authorize 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.
2. Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents 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 of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient's signature: .... Date:.........................
Parent/Responsible Party's Signature:..................................Relationship to patient:.......................

WE EXPECT AND APPRECIATE PAYMENT AT TIME OF SERVICE

WE ACCEPT HICAPS, EFTPOS, MASTERCARD, VISA, CHEQUE AND CASH.

Our Privacy Statement is available at reception.

Staff Check List

- ☐ Medical Form completed and entered
- ☐ Profile Picture taken
- ☐ Form reviewed by dentist and scanned into patient's file