

MEDICAL HISTORY FORM

Paul A Trembath BDS Sc 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

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

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**

PLEASE ANSWER EVERY QUESTION

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

	Yes	No	Details
Are you being treated by a doctor at present?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any medication or tablets?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a prolonged illness?	<input type="checkbox"/>	<input type="checkbox"/>
Or hospitalisation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you normally require Antibiotic Cover before dental treatment? (for Heart Valve disorder or Prosthetic Joints etc)	<input type="checkbox"/>	<input type="checkbox"/>	

Please list any allergies you have:
.....

Have you had any of the following?

	Yes	No		Yes	No
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Gastric reflux	<input type="checkbox"/>	<input type="checkbox"/>	(<input type="checkbox"/> high, <input type="checkbox"/> low)		
Cardiac pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice, Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to non-precious Metals (e.g. nickel in some jewellery)	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve disorder/ Murmur/replacement	<input type="checkbox"/>	<input type="checkbox"/>	Do you Smoke	<input type="checkbox"/>	<input type="checkbox"/>
Have you possibly had any contact with HIV/AIDS virus?				<input type="checkbox"/>	<input type="checkbox"/>
Have you had any ill effects following any dental treatment?				<input type="checkbox"/>	<input type="checkbox"/>
Have you or any relative had any history of prolonged bleeding?				<input type="checkbox"/>	<input type="checkbox"/>
Have you had any serious problems after a dental extraction?				<input type="checkbox"/>	<input type="checkbox"/>
Do you tend to have any sinus problems?				<input type="checkbox"/>	<input type="checkbox"/>
Have you had any ill effects from an antibiotic? Which type/s?.....				<input type="checkbox"/>	<input type="checkbox"/>
Have you had any ill effects from a local anaesthetic?				<input type="checkbox"/>	<input type="checkbox"/>
Do you regularly take Aspirin or other similar medications?				<input type="checkbox"/>	<input type="checkbox"/>
On exertion, do you have chest pains, shortness of breath or palpitations?				<input type="checkbox"/>	<input type="checkbox"/>
<u>Ladies</u> , are you or might you be pregnant? Due date?.....				<input type="checkbox"/>	<input type="checkbox"/>

Any other medical condition?.....

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

Date..... Signature.....
(Parent or guardian if under 18 years)

Our Privacy Statement is available at reception.

Have you had any of the following?

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

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.