BURWOOD DENTAL CENTRE

144 Burwood Road, Burwood NSW 2134
Ph: 9747 4322 Fax: 9744 0831

PATIENT MEDICAL / PERSONAL HISTORY AND REGISTRATION

(Your health information will be treated with the utmost confidentiality. Patients can view or make corrections to their records at any time. This information may be shared with health care professionals for your benefit. Disclosure will not be made to any person not involved in your treatment or the administration of this practice without your consent.)

PATIENT DETAILS:

Mr/Mrs/Miss/Ms.. Surname:……..Given Names:…….….

Address:…..…….……

Suburb:……..…….Post Code:……Date of Birth:.…….……...

Home Phone:……..…Work Phone:……...Mobile:……

E-mail Address:……Occupation:…….…….…….

Are you in a Private Health Fund? Yes / No...Fund Name……..…….Do you have dental benefits? Yes / No

Whom may we thank for referring you?……...…….……

Name of relatives (if any) treated by our practice:…….

Preferred form of appointment confirmation: Telephone, SMS or email ……

ACCOUNT DETAILS – Person responsible for fees if not the patient.

Mr/Mrs/Miss/Ms.. Surname:……..Given Names:…….….

Address:…..…….……

Suburb:……..…….Post Code:……Date of Birth:.…….……...

Home Phone:……..…Work Phone:……...Mobile:……

DENTAL HISTORY:

Why are you seeking dental care?……..

Are you satisfied with past dental treatment?…….……

When was your last dental check up? …….X-rays?……...

Is there anything about dentistry that bothers you?…….....

ARE YOU UNHAPPY OR UNCOMFORTABLE WITH YOUR ? (Please circle)
Smile fillings crowns/bridge gums dentures bite

		YES	NO	NOT SURE
WOULD YOU LIKE ?	Your teeth whitened	❑	❑	❑
	Any missing teeth replaced	❑	❑	❑
HAVE YOU NOTICED ?	Teeth tender to chew on	❑	❑	❑
	Food catching between gums	❑	❑	❑
	Bleeding, sore gums	❑	❑	❑
	Teeth sensitive to hot, cold &/or sweet	❑	❑	❑
	Colour change of fillings, gums	❑	❑	❑
	Swellings, lumps, sores	❑	❑	❑
	Jaw &/or facial muscle tenderness	❑	❑	❑
	Difficulty opening mouth	❑	❑	❑
	Severe headaches, sinus pain	❑	❑	❑

MEDICAL HISTORY

Name of your G.P. or Medical Practitioner ……..Phone ……..

Are you under medical care or having medical treatment now? YES ☐ NO ☐

If so, for what reason?…….……..

Certain medications may influence the type of dental anaesthetic we use and may need to be ceased prior to dental treatment. Please provide us with a full list of medications, which you take regularly or have taken over the last month..…….……...

…….

Do you Smoke? YES ☐ NO ☐ If so, how many? ……

Do you have or have you suffered from any of the following?	**Please circle**		
Heart Murmur OR Rheumatic Fever	Yes	No	Maybe
Heart Surgery (Valve replacement, Bypass, Transplant or other)	Yes	No	Maybe
Do you take Asprin regularly (three or more times per week)?	Yes	No	Maybe
Other Heart Disorder / Complaint OR Angina	Yes	No	Maybe
Immune System Disorder (Arthritis, Lupus, HIV / AIDS & others)	Yes	No	Maybe
Blood or Bleeding Disorder	Yes	No	Maybe
Gastric reflux	Yes	No	Maybe
Leukaemia	Yes	No	Maybe
Diabetes	Yes	No	Maybe
Fainting / Dizzy Spells	Yes	No	Maybe
Do you have an allergy to latex products?	Yes	No	Maybe
Hepatitis A,B,C,D or E or other Liver Disease	Yes	No	Maybe
Kidney Disease	Yes	No	Maybe
Asthma, Chest or Lung Disorders	Yes	No	Maybe
Epilepsy	Yes	No	Maybe
Cancer	Yes	No	Maybe
Chemotherapy	Yes	No	Maybe
Radiotherapy	Yes	No	Maybe
Do you take a bone-building drug like Fosamax, Zometa, Actonel or Pamidronate?	Yes	No	Maybe
Xerostomia (dry mouth)	Yes	No	Maybe
Candidiasis (oral thrush)	Yes	No	Maybe
Sjogren's Syndrome	Yes	No	Maybe
Joint Replacement – Date:	Yes	No	Maybe
Broken Bones requiring pins or plates	Yes	No	Maybe
Allergies to any medications? – Advise:	Yes	No	Maybe
Have you taken intravenous drugs?	Yes	No	Maybe
Advised by your Doctor that you require Anti Biotic cover before treatment?	Yes	No	Maybe
Women – might you be pregnant?	Yes	No	Maybe
Is there anything you would like to discuss in private with the dentist?	Yes	No	Maybe

DATE……..…**PATIENT SIGNATURE**……..…….….**CLINICIAN SIGNATURE**……

Please present your I.D to reception.