fresh dental care

NEW PATIENT
Medical History Form

Welcome to our Practice

Please answer these questions as completely as possible. It will assist us greatly in our effort to provide the best dental treatment for you.

Patient details

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

Surname: _____ Given name: _____ D.O.B: _____

Residential address: _____

Suburb: _____ State: _____ Postcode: _____

Postal address (if different): _____

Home phone: _____ Work phone: _____ Mobile: _____

Email: _____

☐ We may send out email communications to you from time to time, including appointment reminders and our regular newsletter. If you are not happy for us to do so, please indicate by ticking this box.

Occupation: _____

Private health insurer: _____

Emergency contact: _____

Phone: _____ Relation: _____

GP name: _____ GP phone: _____

GP address: _____

Medical history

☐ Angina
☐ Artificial heart valve
☐ Blood pressure
  ○ Low ○ High
☐ Cardiac surgery/pacemaker
☐ Congenital heart defect
☐ Heart disease
☐ Heart murmur
☐ Stroke
☐ Blood thinner medication
☐ Bleeding disorder
☐ Rheumatic fever
☐ Osteoporosis
☐ COPD
☐ Asthma
☐ Thyroid disorder
  ○ Underactive ○ Overactive
☐ Reflux
☐ Immune deficiency
☐ Rheumatoid Arthritis
☐ Kidney/liver disease
☐ Artificial joint
☐ Diabetes
  ○ 1 ○ 2
☐ Hepatitis
  ○ A ○ B ○ C ○ D
☐ HIV positive
☐ Cancer
Type: _____
☐ Radiation/chemotherapy
☐ Neurological disorder
☐ Psychiatric care
☐ MS
☐ Epilepsy
☐ Steroid therapy

Are you currently taking MEDICATION (inc. natural supplements)? If yes, please list:

_____

Please tick: ☐ Smoker ☐ Non-smoker ☐ Ex-smoker

Are you pregnant? ☐ Yes ☐ No If yes, due date: _____

Were you taking any MEDICATION before getting pregnant? If yes, please list:

_____

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Allergies/intolerances

☐ Yes ☐ None

☐ Aspirin ☐ Iodine ☐ Latex ☐ Penicillin ☐ Sulpha drugs

☐ Other (please specify): _____

Dental history

Last dental visit: _____

Have you ever had a reaction or complication following dental treatment in the past? ☐ Yes ☐ No

If yes, please detail: _____

Do you have any private or confidential information you wish to discuss in private and not write down?

☐ Yes ☐ No

Are you suffering from any of the following?

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

Has anyone ever told you that you snore? ☐ Yes ☐ No

After 6-7 hours of sleep do you wake up refreshed? ☐ Yes ☐ No

How did you find out about us?

☐ Google/web ☐ Radio ☐ Location ☐ Bupa store ☐ FDC staff ☐ Facebook

☐ Family Friend ☐ GP/Dentist – name: _____

☐ Preschool/school ☐ Print advertisement ☐ GP ☐ Yellow Pages/local directory

☐ Other (please specify): _____

☐ Referred by friend/family _____

Anything else you would like to tell us: _____

_____

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 online at www.bupadental.com.au/privacy-policy.
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 dependents. 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: _____

(Parent/Guardian to sign if patient is a minor)