

Health history form

So we can ensure we are looking after your needs, please review and complete the following questionnaire:

Surname: (Mr/Mrs/Miss/Ms/Dr):	First name:
Date of birth:	Address:
Postcode:	Home phone:
Work phone:	Mobile:
Email:	Occupation:
Name of person responsible for fees, if not self:	Address:

Recommended by: _____

Purpose of visit: _____

Dental insurance company: _____

Is another member of your family a patient at our office? Yes No

Have you had any of the following?

- | | | | |
|----------------------|---------------------------|---------------------------------|---------------------------|
| Heart Problems | <input type="radio"/> Yes | Allergies to anaesthetics | <input type="radio"/> Yes |
| Blood pressure | <input type="radio"/> Yes | Allergies to penicillin | <input type="radio"/> Yes |
| Artificial joints | <input type="radio"/> Yes | Allergies to medications | <input type="radio"/> Yes |
| Rheumatic fever | <input type="radio"/> Yes | Allergies to latex | <input type="radio"/> Yes |
| Circulatory problems | <input type="radio"/> Yes | Anemia or other blood disorders | <input type="radio"/> Yes |
| Radiation treatment | <input type="radio"/> Yes | Diabetes | <input type="radio"/> Yes |
| Excessive bleeding | <input type="radio"/> Yes | Asthma | <input type="radio"/> Yes |
| Excessive bruising | <input type="radio"/> Yes | Hepatitis A B C D E | <input type="radio"/> Yes |
| Ulcers (stomach) | <input type="radio"/> Yes | Epilepsy | <input type="radio"/> Yes |
| Sinus trouble | <input type="radio"/> Yes | Liver or kidney problems | <input type="radio"/> Yes |
| Tumor History | <input type="radio"/> Yes | | |

Are you currently taking any medications? Yes No

If 'yes', please list: _____

Have you had any of the following?

- | | | | |
|--|---------------------------|--|---------------------------|
| Does your jaw click or hurt? | <input type="radio"/> Yes | Do you smoke? | <input type="radio"/> Yes |
| Do you feel you grind your teeth? | <input type="radio"/> Yes | Do you think you have occasional bad breath? | <input type="radio"/> Yes |
| Have you ever had orthodontic treatment? | <input type="radio"/> Yes | Do you experience sensitivity when you brush your teeth? | <input type="radio"/> Yes |
| Do you wear a night guard? | <input type="radio"/> Yes | Does floss ever tear between your teeth? | <input type="radio"/> Yes |
| Have you ever had gum disease? | <input type="radio"/> Yes | Does food get jammed between your teeth? | <input type="radio"/> Yes |
| Have you ever had your bite adjusted? | <input type="radio"/> Yes | Do you experience sensitivity with hot/cold? | <input type="radio"/> Yes |
| Do you bite your lips or cheek often? | <input type="radio"/> Yes | Do your teeth ever hurt when bite hard? | <input type="radio"/> Yes |

Other notes: _____

Name of your Physician: _____

Address: _____

Phone _____

Are you pregnant? Yes No

How long since your last dental appointment? _____

How often do you have dental examinations? _____

Previous dental x-rays were taken: Less than a year ago Longer than a year ago

Consent for treatment

I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such a diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. 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 that this data may be reviewed by team members of the dental practice.

Patient signature: _____ Date: _____

Parent/responsible party's signature: _____

Relationship to patient: _____