JC DENTAL
Southport Park Village

MEDICAL & DENTAL HISTORY

Your privacy is important to us and all information provided to us on this form will remain strictly confidential.

TITLE: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr FIRST NAME: _____

PREFERRED NAME: _____ SURNAME: _____

DATE OF BIRTH: / / ADDRESS: _____

MOBILE: _____ _____ postcode: _____

OTHER NUMBER: _____ EMAIL: _____

OCCUPATION: _____ HEALTH FUND: _____

EMERGENCY CONTACT name: _____ mobile: _____

If under 18 years, GUARDIAN name & contact: _____

REFERRED BY: ☐ Google ☐ other website ☐ walked past ☐ printed ad ☐ other:

☐ word of mouth (please provide name so we can thank them): _____

What is the main purpose of your visit today? _____

When was your last visit to the dentist? ☐ days ☐ weeks ☐ months ☐ years ☐ can't remember

Does dental treatment make you nervous? ☐ not at all ☐ a little ☐ sometimes ☐ most of the time ☐ always

Are you experiencing any of the following? (please tick all that apply)

☐ sensitivity to hot or cold	☐ bleeding gums	☐ holes in teeth or broken fillings
☐ food trapping between teeth	☐ teeth eroding away	☐ roughness of existing fillings
☐ clicking/pain in the jaw joints	☐ discoloured fillings	☐ dry mouth
☐ staining of your teeth	☐ bad breath	☐ other _____

Are you concerned with any of the following? (please tick all that apply)

☐ existing crowns/bridges/dentures	☐ tooth cleaning techniques	☐ discoloured teeth or fillings
☐ ability to eat	☐ my smile	☐ receding gums
☐ crooked teeth	☐ silver fillings	☐ previous dental treatment
☐ missing teeth	☐ gaps between your teeth	☐ other _____

Are you aware of any grinding or clenching habits? ☐ NO ☐ YES ⟶ have you ever sought treatment? Y / N

Do you smoke? ☐ NO ☐ YES ⟶ how long have you smoked for? _____ how many per day? _____

Ladies, are you pregnant? ☐ NO ☐ NO BUT CURRENTLY BREASTFEEDING ☐ YES ⟶ how many months? _____

PLEASE TURN OVER

We understand that you may have medical information that you do not wish to write down or may need clarification on any of the following. Please tick this box ☐ if you would prefer to speak to the dentist about your medical history.

Please tick all medical conditions that are relevant to you (past AND present):

☐ HEART	☐ high blood pressure ☐ pacemaker ☐ rheumatic fever ☐ chest pain ☐ low blood pressure ☐ heart attack ☐ heart murmur ☐ heart surgery ☐ other / details: _____
☐ RESPIRATORY	☐ asthma (please bring your puffer) ☐ COPD ☐ sinus problems ☐ cystic fibrosis ☐ other / details: _____
☐ NEUROLOGICAL	☐ stroke ☐ epilepsy ☐ Parkinson's ☐ Alzheimer's / dementia ☐ other / details: _____
☐ BLOOD	☐ excessive bleeding ☐ bruise easily ☐ anaemia ☐ leukemia ☐ haemophilia ☐ other / details: _____
☐ BONE	☐ artificial joints ☐ osteoporosis ☐ rheumatoid arthritis ☐ osteoarthritis ☐ other / details: _____
☐ LIVER & KIDNEY	☐ type I diabetes ☐ type II diabetes ☐ cirrhosis ☐ hepatitis A / B / C ☐ other / details: _____
☐ CANCER	☐ where? _____ ☐ radiation therapy ☐ chemotheraphy ☐ surgery ☐ other / details: _____
☐ PSYCHOLOGICAL	☐ anxiety ☐ depression ☐ schizophrenia ☐ post-traumatic stress disorder ☐ excessive stress ☐ alcohol or substance abuse ☐ anorexia or bulimia ☐ other / details: _____
☐ OTHER	☐ reflux / gastritis ☐ HIV / AIDS ☐ hyperthyroidism ☐ hypothyroidism ☐ vertigo ☐ tuberculosis ☐ transplant, where? _____

Please list any other medical conditions relevant to you: _____

_____

Are you aware of any allergies? ☐ NO ☐ YES ⟶ please list: _____

Are you currently taking any medications? ☐ NO ☐ YES ⟶ please list: _____

_____

Consent for services

I, the undersigned, consent to the performing of dental procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated and I will assume responsibility for the fees associated with those procedures. I am aware that payment is required on the day of treatment.

_____ _____/_____/_____

(Patient signature) (Date of signature)