Health History Form

Mr/Mrs/Miss/Ms/Dr	Other:
First Name:	Surname:
Date of Birth:	Address:
Mobile/Home:	Occupation:
Email:	Who can we thank for referring you:
Emergency Contact Name and phone:	Private Health Insurance:

Have you had any of the following?

Heart Problems ❍ Yes ❍ No If yes, more information:_______________________________________

Osteoporosis ❍ Yes ❍ No

High Blood Pressure ❍ Yes ❍ No

Low Blood Pressure ❍ Yes ❍ No

Artificial joints ❍ Yes ❍ No

Asthma ❍ Yes ❍ No

Rheumatic fever ❍ Yes ❍ No

Circulatory problems ❍ Yes ❍ No

Radiation treatment ❍ Yes ❍ No

Excessive bleeding ❍ Yes ❍ No

Excessive bruising ❍ Yes ❍ No

Ulcers (stomach) ❍ Yes ❍ No

Sinus trouble ❍ Yes ❍ No

Tumor history ❍ Yes ❍ No

Allergies to local anaesthetic ❍ Yes ❍ No

Allergies to medications ❍ Yes ❍ No

Please list:______________________________

Allergies to latex ❍ Yes ❍ No

Anaemia/blood disorders ❍ Yes ❍ No

Diabetes Type 1 or 2 ❍ Yes ❍ No

Epilepsy ❍ Yes ❍ No

Hepatitis A B C ❍ Yes ❍ No

HIV ❍ Yes ❍ No

Liver or kidney problems ❍ Yes ❍ No

Have you any hospitalisation or operation in the last 12months? ❍ Yes ❍ No if yes, What was the surgery for?____

Are you pregnant? ☐ **Yes. If yes, what is the due date?** ____________________

Are you currently taking any medications? ❍ Yes ❍ No **If 'yes', please list:**

List:

How long since your last dental appointment? ____________________________

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

Have you had any of the following?

Does your jaw click or hurt?	❍ Yes	❍ No
Do you feel you grind your teeth?	❍ Yes	❍ No
Do you smoke or vape?	❍ Yes	❍ No
Do you think you have bad breath?	❍ Yes	❍ No
Have you ever had orthodontic treatment?	❍ Yes	❍ No
Do your gums ever bleed when you brush your teeth?	❍ Yes	❍ No
Do you wear a night guard?	❍ Yes	❍ No
Do you experience sensitivity with hot/cold?	❍ Yes	❍ No
Have you ever had gum disease?	❍ Yes	❍ No
Does floss ever tear between your teeth?	❍ Yes	❍ No
Does food get jammed between your teeth?	❍ Yes	❍ No
Do you bite your lips or cheek often?	❍ Yes	❍ No
Do your teeth ever hurt when you bite hard?	❍ Yes	❍ No

Other notes ____

Consent for treatment

I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate to provide a thorough diagnosis. Once my diagnosis has been explained, I authorise the dentist to carry out the recommended treatment that we mutually agree upon, and to use any necessary clinical assistance to ensure proper care.

I consent to the use of anaesthetics, sedatives, and other medications as required, and I acknowledge that all anaesthetic agents carry certain risks. I understand I may request a full explanation of any potential complications at any time.

I agree to be responsible for payment of all services provided to me or my dependants. Payment is due at the time of service unless prior arrangements have been made**. I understand that a Failed to Attend or Late Cancellation fee of $150 applies if an appointment is cancelled or rescheduled within 48 hours.**

I authorise the dental practice team to review and access this information as required for my care**.**

Patient signature: ________________________ **Date:** _______________

Parent/ responsible party's signature: ____________________________________

Relationship to patient: _____________________________

Office Use Only:

Clinician signature____________________ **Date**_________________ **Entered:** **Scanned:**