Health History Form

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

Mr/Mrs/Miss/Ms/Dr Surname:	**First Name:**
Date of Birth:	**Address:**
Postcode:	**Home Phone:**
Work Phone:	**Mobile:**
Email:	**Occupation:**
Emergency Contact Name:	**Emergency Contact Phone Number/s:**

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	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Blood Pressure	☐ Yes	☐ No	Allergies to anaesthetic	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No	Allergies to medications	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Please list:_____		
Rheumatic fever	☐ Yes	☐ No	Allergies to latex	☐ Yes	☐ No
Circulatory problems	☐ Yes	☐ No	Anemia/blood disorders	☐ Yes	☐ No
Radiation treatment	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Excessive bleeding	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Excessive bruising	☐ Yes	☐ No	Hepatitis A B C	☐ Yes	☐ No
Ulcers (stomach)	☐ Yes	☐ No	HIV	☐ Yes	☐ No
Sinus trouble	☐ Yes	☐ No	Liver or kidney problems	☐ Yes	☐ No
Tumor history	☐ Yes	☐ No			

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?	☐ Yes	☐ No	
Do you feel you grind your teeth?	☐ Yes	☐ No	
Do you smoke?	☐ Yes	☐ No	__ per day
Do you think you have occasional 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	
Have you ever had your bite adjusted?	☐ Yes	☐ No	
Do your teeth ever hurt when you bite hard?	☐ Yes	☐ No	

Other notes _____
_____

Name of your physician: _____
Address: _____
Phone: _____

Are you pregnant?. Yes. If yes, what is the due date? _____

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
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 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 anaesthetics', sedatives and other medication as necessary. I fully understand that using 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: _____