RUSSELL LEA DENTAL CARE
230 Lyons Road
Rusell Lea NSW 2046

MEDICAL HISTORY FORM

Tittle: (Mr/Mrs/Miss/Dr/Other) : ……..
First Name: ……
Surname: ……
Contact Number: ……
Email: ……
Address: ……..
……
……
Postcode: …… State: ……
Date of Birth: ……
Gender: ……
Driver's Licence: ……

Occupation: ……
Emergency contact name: ……
Emergency contact number: ……..
Relationship: ……
Person responsible for payment of account:
……..
Private Health Fund/DVA Name :
……..
Are you eligible for the Child Dental Benefit Scheme?
YES ◯ NO ◯ If yes,please provide your:
Medicare Number: ……
Reference Number: ……

DENTAL HISTORY

What is your home Oral Health routine:
Brush (manual/electric) ◯ - Floss ◯
- Mouthwash ◯
Who was your previous / usual general dentist?
……
How long since your last dental visit:
……..
When were your last DENTAL X-RAYS taken:
……
Are teeth sensitive to:
Cold ◯ Sweets ◯ Biting or chewing: ◯

Have you experienced:

Clicking or popping of the jaw?	
Ear, face, jaw pain?	
Difficulty opening or closing your mouth?	
Difficulty chewing?	
Cold sores or blisters around your mouth?	
Loose teeth or a change in your bite?	
Food trapping between your teeth?	
Bleeding gums (when cleaning your teeth)?	
Swelling of lumps present in mouth?	
Dry socket?	

Do you like the appearance of your teeth:
Yes ◯ No ◯
If no, what would you like to improve:

Do you:

Grind or clench your teeth?	
Wear a dental night guard?	
Have aching jaws, especially in the mornings?	
Have a dry mouth?	
Suffer from occasional bad breath?	
Have a history of gum disease or tooth loss?	
Bite your cheeks, lips, or tongue often?	
Snore?	
Chew only on one side?	

Have you ever had:

Orthodontic treatment?		
Periodontal (gum) treatment?		
Your bite adjusted?		
Any teeth removed?		
Oral surgery?		
Sore gums?		
Change in appearance of the face?		
Falling asleep or staying asleep?		
Frequent headaches, neckaches or backaches?		
A serious injury to your mouth or head?		
If yes, please describe the injury:		

MEDICAL HISTORY

Is important to know details about your medical history as these could affect the success of your dental treatment and how we can provide this treatment safely for you. The information you provide is confidential and will be handled in accordance with our privacy policy.

Are you receiving any medical treatment at present? Yes ◯ No ◯

If yes, please provide details: ……

Name of your medical practitioner/specialist: ……..

Surgery contact number :…….

Have you been hospitalised in the last 12 months: Yes ◯ No ◯

If yes, please list why: ……

Are you taking any medication or supplements? Yes ◯ No ◯

If yes, please list: ……

Please indicate if you have had or are being treated for any of the following:

Heart condition/Heart surgery	
Diabetes	
Blood pressure (High / Low)	
Heart Valve/Pacemaker	
Stroke	
Rheumatic Fever	
Digestive problems, gastroesophageal Reflux	
Kidney disease	
Circulatory problems, excessive bleeding	
Thyroid disease	
Asthma	
Hay fever	
Liver disease	
Epilepsy or Seizures	
Depression/Anxiety	
Cancer	
Arthritis/Rheumatism	
Bone disorder or disease(osteoporosis)	
Other:	

Are you:

A current smoker/vaper?	
If yes how many per day?	
A past smoker/vaper?	
If so, when did you quit?	
Pregnant?	
Breast feeding?	
On any form or oral contraceptive?	

Do you have any allergies to

Penicillin	
Sulphur	
Aspirin	
Iodine	
Seafood	
Paracetamol	
Other:	

CONSENT FOR TREATMENT

1.- I have answered all questions to the best of my knowledge. Should further information be required, you have my permission to contact my medical practitioner, who may release such information to you.

2.- I consent to a dentist or designated team member to take x-rays, study models, photographs and other diagnostic aides as deemed appropriate by a dentist to make a thorough dental diagnosis.

3.- I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. I also understand that if for any reason recovery of my funds is required, and costs involved will be at my expense. I understand that if I cancel an appointment within 24 hours of my appointment, I may be liable for payment of a cancellation fee.

4.- I agree to the Clinical Team using any photographs and x-rays they take for educational purposes.

Patient name: …… Date:……

Patient Signature: …… Parent/Guardian: ……