Paddington Dentistry

Medical History Form

Dear Patient, Welcome to Paddington Dentistry. Please take your time to answer these questions accurately. This will assist us in our effort to provide the optimum dental care for you. All information will be treated with complete confidentiality.

☐Mr ☐Mrs ☐Miss ☐Ms First name ……Surname ……

Preferred name……Date of birth ……/……/…… Email ……

Home address……Suburb……Postcode……

Phone (Mobile)……(Home)……(Work) ……

Medicare Card No .. …… Veterans' Affair card No……Occupation ……

Health fund for dental cover……Membership No……

Your Medical Practitioner : Name……Contact No……Practice Name……

Emergency contact name …… Relationship to patient……Phone……

Reason for making appointment: ……

Are you satisfied with the way your teeth look ?……

Are you interested in teeth whitening ? ……

How long since your last dental appointment ?……

How did you hear about us: ☐Google search ☐Friend/Family ☐Yellow pages ☐Other……

Medical Questionnaire – Private and Confidential

Are you receiving any medical treatment at present	Y☐ N☐	Details……	
Have you had any serious or long standing illness	Y☐ N☐	Details……	
Have you ever been hospitalised	Y☐ N☐	Details……	
Do you have any allergies	Y☐ N☐	Details (if yes) ……	
(Ladies) Are you pregnant	Y☐ N☐	Due date (if yes)……	

Please indicate if you have EVER had any of the following:

Any heart complaint/treatment	Y☐ N☐	Thyroid disease	Y☐ N☐
Rheumatic fever or heart valve surgery	Y☐ N☐	Any nervous system disorder	Y☐ N☐
High or low blood pressure	Y☐ N☐	Hepatitis A,B,C,D/Liver disease	Y☐ N☐
Diabetes	Y☐ N☐	Asthma/Bronchitis /lung conditions	Y☐ N☐
Anti-coagulant therapy	Y☐ N☐	Radiation therapy/chemotherapy	Y☐ N☐
Joint replacement surgery	Y☐ N☐	Tuberculosis	Y☐ N☐
Osteoporosis or low bone density	Y☐ N☐	Gastric ulcer/GI disease	Y☐ N☐
Epilepsy	Y☐ N☐	History of cancer treatment	Y☐ N☐
Blood disorders	Y☐ N☐	Transplanted organ or bone marrow	Y☐ N☐
HIV	Y☐ N☐	Sleep apnea	Y☐ N☐
Do you smoke	Y☐ N☐	Other ……	

Current medications (prescription, over the counter, herbal)……

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I agree that the above is a true and accurate record based on my best knowledge. I understand that Paddington Dentistry requires payment on the day of treatment unless otherwise discussed with treating dentist. I hereby give my authority for the dentist to use diagnostic aids deemed appropriate 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 further acknowledge that failure to attend any appointment without notice may also result in a deposit requirement prior to future appointments being scheduled.

PLEASE NOTE: The medical history form will be electronically copied to your clinical record file and the original will be subsequently destroyed. By signing this document you agree to this process. This form is a guide only and you should discuss any relevant matters with your dentist prior to the commencement of any dental treatments.

Patient signature

Parent / Responsible Party's signature Date : / /