MEDICAL HISTORY

Title: Mr Mrs Ms Miss Master Dr. Other: _____
Surname:_____
Given Name:_____
Preferred Name:_____ Date of Birth: _____/_____/_____
Postal Address:_____
State: _____ Post Code: _____
Home Phone:_____ Work Phone:_____
Mobile:_____ Email: _____@_____

We will send you email communications from time to time, including appointment reminders, recall reminders, and our regular newsletter. Please tick this box if you don't wish to receive communication from us. ( )

Do you have Dental Insurance? Yes No If yes, which fund? _____

Please indicate your preferred method of appointment confirmation: ( )SMS ( )Telephone ( )Email

Medical Doctor - Name : _____Contact: _____

Are you allergic to any medication? No Yes, If yes, please specify:_____
Women, are you pregnant? No Yes, If yes, please specify: _____
Do you smoke? No Yes If yes, please specify: _____
Do you drink alcohol? No Yes If yes, please specify: _____
Recreational Drug Usage? No Yes If yes, please specify: _____

Do you have any present illness? No Yes If yes, please specify: _____
Please circle any of the following below that applies to you:

Stomach or Digestive problems, Bleeding Disorders, Heart Murmur/ Heart Disease, Stroke Blood Pressure: High Low, Hepatitis: A B C, Thyroid Disorder, Angina, Diabetes: Type 1 Type 2, Nervous or Psychiatric Condition, Artificial Heart, Valves/Valve Defect, Epilepsy, Rheumatic Fever, Asthma, Heart Attack . Others _____

Are you currently taking any medication? Including herbal/dietary supplements, or naturopathic medicine. No Yes, If yes, please specify:_____
_____

Patient Details

Medical History → Please circle – Bisphosphonates, Bone Disease, HIV Positive, Congenital Heart Defect, Cancer Therapy, Infectious Diseases: _____
Kidney Trouble, Cardiac Surgery/Pacemaker , Joint Replacement: _____
Other: _____

When did you have your last Dental visit? _____
Do you present with any pain or any concerns regarding your oral health? No Yes _ If yes, please, describe in a few words what is happening _____
_____
How often do you brush your teeth?_____
Do you floss? How often? _____
Is there anything that you would like to discuss with the dentist regarding oral health or the appearance of your smile?_____
_____

Sleep Apnea - Have you been diagnosed with Sleep Apnea? No Yes If yes, are you currently using any Sleep Apnea Devices? No Yes

For the dentist to assess and discuss further for possible Obstructive Sleep Apnea, please tick any that apply: ( ) Excessive snoring ( ) Daytime Tiredness ( ) Partner notices you stop breathing ( ) Lack of energy ( ) Choking or gasping during ( ) Poor concentration/memory ( ) Frequent visits to the bathroom during the night ( ) Falling asleep during the day

Materials Dental or restorative materials are used to replace loss of tooth structure. A large range of restorative materials are available, and their characteristics vary according to their intended purpose:

( ) I am happy to let the dentist choose the appropriate material for each restorative situation, based on the knowledge of the materials properties, bio-compatibility, aesthetics and applications.

( ) I wish to further discuss with dentist the materials to be used.

FOR YOUR COMFORT: Many people are still nervous about coming to the dentist. Whilst the improvements in techniques and anaesthetics have helped most people, you may still be apprehensive and wish us to take extra measures for your comfort.

Please circle the number that indicates your present level of apprehension. Completely at

Ease 0 1 2 3 4 5 6 7 8 9 10 Petrified

Is there anything you would like to discuss in private with the dentist: Yes No

Dental History - Additional Considerations

_____
_____
_____
_____

No accounts are kept in this office; hence it is practice policy that payments are to be made on the day of treatment.

Patients Signature:

_____ Date: ___/___/_____

The Commons - Shops 9/10, 480 Casuarina Way - Casuarina NSW 2487.
☎ 02 6678 2220 Fax 02 6678 2230 www.casuarinadental.com.au.