



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: _____@_____
 Next of Kin: _____ Mobile: _____

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

📧 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: _____

📏 Weight: _____ 📏 Height: _____

🏠 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 _____

2/2

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

How did you hear about us? _____

Do you give consent for the use of photos/videos to be used on social media and or advertising?

Please circle No Yes

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

✦ 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. ()

Patients Signature:

_____ Date: ___/___/_____

The Commons - Shops 9/10, 480 Casuarina Way - Casuarina NSW 2487.

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