richmond road
DENTAL

Confidential Medical and Dental History Form

PATIENT DETAILS

Mr Mrs Miss Ms Dr | Full Name: | DOB: / /

Address:

Postal Address if different:

Phone Numbers: Home Work Mobile

E-Mail Address:

Preferred method of confirmation for your appointments: Phone - work/home/mobile *OR* e-mail *OR* SMS

Occupation: | Dental Health Fund:

Emergency Contact: Name Ph: Relationship:

REFERRAL INFORMATION - please tell us how you heard about Richmond Road Dental

Google Search Facebook Yellow Pages Online Location Signage Advertising Word of Mouth Other:

DENTAL HISTORY

Does dental treatment make you nervous? No Slightly Moderately Extremely

Do you gag easily when receiving dental treatment?	YES	NO
Have you been advised you require antibiotic cover before dental treatments?	YES	NO
Do you have any abnormal reactions to local or general anaesthesia?	YES	NO
Do you participate in competitive sports?	YES	NO
Do you consume soft drinks, lemon juice or sports drinks more than twice per week?	YES	NO
Are you a smoker?	YES	NO
For females - are you, or do you think you are pregnant?	YES	NO
Is there anything you wish to discuss privately with the dentist?	YES	NO

MEDICAL HISTORY

Do you, or have you ever had any of the following? **PLEASE CIRCLE Y or N**

Y N - Heart Condition or Disorder
Y N - Rheumatic Fever or Heart Valve Problems
Y N - Heart Pacemaker
Y N - Diabetes
Y N - Epilepsy
Y N - Cancer/Treatment For Any Kind of Cancer
Y N - High or Low Blood Pressure
Y N - Osteoporosis or Low Bone Density
Y N - Blood Disease/Disorder eg. Anaemia
Y N - High Cholesterol
Y N - Thyroid Disease
Y N - Anxiety or Depression
Y N - Sleeping Disorder eg. Sleep Apnoea

Y N - Kidney Disease/Transplant
Y N - Liver Transplant
Y N - Hepatitis A,B,C or Other Liver Diseases
Y N - HIV/AIDS
Y N - Asthma
Y N - Hay Fever
Y N - Sinusitis
Y N - Fainting
Y N -Tuberculosis
Y N - Joint Replacement Surgery
Any Other Condition(s)

Allergies or adverse reactions eg; medications, foods, latex, pollen:

Current Medications and dosage:

Health Supplements: eg glucosamine, fish oil, St John's Wort etc.

Are you taking any medication to treat osteoporosis?	YES	NO
Are you taking any medication to thin the blood?	YES	NO

Your Medical Practitioner Details: Name Suburb

CONSENT FOR SERVICES

I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic and other medication as indicated and I will assume responsiblity for the fees associated with those procedures.
I hereby authorize the dentist to take x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis.

PATIENT/PARENT/LEGAL GUARDIAN

Print Name:	Signature:	Date / /
Updated:	Signature:	Date / /
Updated:	Signature:	Date / /