Richmond Road
DENTAL

Confidential Medical and Dental History Form

PATIENT DETAILS		
Mr Mrs Miss Ms Dr Other	NAME:	
DOB: / /	Preferred Name:	Pronouns:
E-Mail Address:		
Address:		
Postal Address if different:		
Phone Numbers: Home	Work	Mobile
An SMS reminder/confirmation is our preferred contact. Specify if different: Email/Call		
Occupation:	Dental Health Fund: Y / N	
Emergency Contact: Name	Ph:	Relationship:

REFERRAL INFORMATION - please tell us how you heard about Richmond Road Dental	
Google Search / Facebook / Location / Signage / Word of Mouth -> Name:	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? **If yes,** what sport?	YES	NO
Do you consume soft drinks, lemon juice or sports drinks more than twice per week?	YES	NO
Are you a smoker / vape user? **If yes,** how many per day?	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 - Kidney Disease/Transplant
Y / N - Rheumatic Fever or Heart Valve Problems	Y / N - Liver Transplant
Y / N - Heart Pacemaker	Y / N - Hepatitis A,B,C or Other Liver Diseases
Y / N - Diabetes	Y / N - HIV/AIDS
Y / N - Epilepsy	Y / N - Asthma
Y / N - Cancer/Treatment For Any Kind of Cancer	Y / N - Hay Fever
Y / N - High or Low Blood Pressure **(please circle high or low)**	Y / N - Sinusitis
Y / N - Osteoporosis or Low Bone Density	Y / N - Fainting
Y / N - Blood Disease/Disorder eg. Anaemia	Y / N - Tuberculosis
Y / N - High Cholesterol	Y / N - Joint Replacement Surgery
Y / N - Thyroid Disease	Y / N - Jaw Pain
Y / N - Anxiety or Depression	Y / N - Dry Mouth
Y / N - Sleeping Disorder eg. Sleep Apnoea	Any Other Condition(s)

ALLERGIES or adverse reactions eg; medications, foods, latex, pollen. **Y / N - Please list details.**

Current Medications and dosage:

Health Supplements: eg glucosamine, fish oil, St John's Wort etc.	
Are you taking any medications, or receiving injections or infusions 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 AND COLLECTION OF PRIVATE INFORMATION

Richmond Road Dental (ABN: 29 094 136 044) collects, holds uses and discloses personal information in accordance with our privacy policy. If you provide your personal information (including sensitive health information) to us, you consent to us collecting, holding, using and disclosing that personal information in accordance to the privacy policy.

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.

PATIENT/PARENT/LEGAL GUARDIAN

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