NEW PATIENT DENTAL / MEDICAL HISTORY FORM

Shop 1, 122 Hobart Road
Kings Meadows, TASMANIA 7054
Phone: 63 43 4222
Email: info@kmdp.com.au
Web: www.kmdp.com.au

Antonie Nohra D.D.S
Nedine Moir B.D.S (Sydney)

Title:_____ Surname:_____
Given Names:_____ Preferred name: :_____
Date Of Birth:_____/_____/_____
Address:_____
_____Suburb:_____Postcode:_____

Ph (Home):_____ Ph (Work): _____
Ph (Mobile): _____ E-mail:_____

Occupation:_____
Reminder System (please tick):
We remind our patients of their appointments. If you would like us to do this please indicate the preferred means of contact.

☐ SMS ☐ Mobile ☐ Home Phone ☐ Work Phone ☐ E-mail

Name of Private Health Fund (e.g. St Lukes, CBHS, BUPA):_____

Membership Number:_____Position Number on Card:_____

Contact in case of emergency:_____Ph:_____
Relationship to you: _____

How did you hear about us? _____
Referred by another patient *who?* _____

What is the purpose of your visit today? _____
When was your last dental visit? _____

Please tick any dental concerns you have?

- ☐ Toothache
- ☐ Sensitive teeth
- ☐ Bleeding gums
- ☐ Loose teeth
- ☐ Bad breath
- ☐ Dry mouth
- ☐ Missing teeth
- ☐ Difficulty chewing
- ☐ Wisdom teeth
- ☐ Unsatisfactory denture
- ☐ Rapidly decaying teeth
- ☐ Lost filling/cavity
- ☐ Grinding/clenching teeth
- ☐ Worn, broken teeth
- ☐ Pain in face or jaw joints
- ☐ Sounds from joint
- ☐ Bad appearance of teeth
- ☐ Discoloured teeth

How do you feel about today's appointment? (please circle)

Very relaxed→→ Relaxed→→ A little anxious→→ Nervous→→ Phobic

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Medical History

How do you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Who is your general practitioner? _____

Telephone: _____

Have you had or are you suffering from any of these? (please tick)

Heart Trouble / Surgery If yes, please say when you last had heart trouble or surgery……	☐	Asthma Hospitalised for asthma in last 12 months	☐ ☐
Cardiac Pacemaker	☐	Nervous disorders	☐
High Blood Pressure	☐	HIV/AIDS	☐
Low Blood Pressure	☐	Liver or Kidney Disease	☐
Diabetes Type 1……. Type 2…….	☐	Are you taking blood thinners? Please specify	☐
Hepatitis	☐	Radiation or Chemotherapy. When (specify)?	☐
Rheumatic Fever	☐	Have you had cancer? If so, where and when?	☐
Arthritis	☐	Prosthetic Implant/Joint Replacement	☐
Thyroid Trouble	☐	Organ or Bone Marrow Transplant	☐
Epilepsy	☐	Steroid Therapy	☐
Sleep Apnoea	☐	Osteoporosis	☐
Stroke, if yes when?	☐	Other (specify)_____	
Are you taking Bisphosphonates or other bone suppressive agents (e.g. Fosamax, Actonel, Denosumab)?	☐	Do you smoke? How many per day?..... How many years?.....	☐
Stomach or Digestive Condition/Reflux	☐	Any other medical conditions? (please state)	☐

Women: Are you pregnant?_____If yes how many months:_____

Are you allergic to anything e.g. latex, penicillin, peanut, etc (please specify and describe reaction):

_____

What medications including natural remedies are you taking (or give the front desk a list)?

_____

_____

Have you ever had Facial Aesthetics Treatment to smooth out wrinkles and/or Treatment for Bruxism (Botox, Dysport etc.)? Please circle YES / NO

Are you happy with your smile? Would you be interested in Invisalign / Alignment / Implants (please circle)

I have accurately completed this pre-clinical questionnaire to the best of my knowledge. I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentists and their staff and I assume full financial responsibility for said treatment on the day of treatment. Note: There will be a fee charged for missed appointments, unless 24 hours' notice is given.

Patient signature: _____
(Parent or Guardian to sign if patient is a minor)

Print Name: _____ Date: ____/____/_____