# **NEW PATIENT HISTORY FORM**



Title (Mr/Mrs/Miss/Ms/Dr/Other):  First Name:  Surname:  Contact Number:  Emergency Contact Number:  Relationship:  Name of person responsible for payment of accounts:  Emergency Contact Number:  Relationship:  Name of person responsible for payment of accounts:  Frist Name:  Relationship:  Name of person responsible for payment of accounts:  Private Health Fund / DVA Name (if applicable):  Are you eligible for the Child Dental Benefits Scheme?  YES	Today's Date:		Occupation:	
First Name:  Surname:  Contact Number:  Email:  Address:  Private Health Fund / DVA Name (if applicable):  Are you eligible for the Child Dental Benefits Scheme?  YES			Emergency Contact Name:	
Surname:  Contact Number:  Email:  Address:  Private Health Fund / DVA Name (if applicable):  Private Health Fund / DVA Name (if applicable):  Are you eligible for the Child Dental Benefits Scheme?  YES  NO  Five please provide your:  Medicare Number:  Medicare Number:  Medicare Number:  Reference Number:  Reference Number:  Medicare	First Name:			
Name of person responsible for payment of accounts:	Surname:			
Email:				
Address:			Name of person responsible for payment of accounts.	
Postcode: State: Mare you eligible for the Child Dental Benefits Scheme?  VES				
Date of Birth:	Address:		Private Health Fund / DVA Name (if applicable):	
Medicare Number:  Are you of Aboriginal or Torres Strait Islander descent?  YES	Postcode:	State:	Are you eligible for the Child Dental Benefits Scheme?	
Medicare Number:  Are you of Aboriginal or Torres Strait Islander descent?  YES	Date of Birth:			
Are you of Aboriginal or Torres Strait Islander descent?  YES	Gender:		Medicare Number:	
DENTAL HISTORY  What is the purpose of your visit today?  How long since your last DENTAL VISIT? Less than 1 year ago Approx. 1 year ago More than 2 years More than 2 years More than 2 years Don't Remember  What is your home oral hygiene routine? (e.g. Electric or manual toothbrush, brush 2 times a day, flossing)  ARE ANY TEETH SENSITIVE TO: Hot or cold? Sweet tastes? Biting or chewing?  HAVE YOU EXPERIENCED: Clicking or popping of the jaw? Ear, face, jaw pain? Difficulty opening or closing your mouth? Loose teeth or a change in your bite? Food trapping between your teeth?  DO YOU: Grind your teeth? Wear a dental night guard? Have a dry mouth? Suffer from occasional bad breath? Suffer from occasional bad breath? Have a history of gum disease or tooth loss? Bite your cheeks, lips or tongue often? HAVE YOU EVER HAD: Orthodontic treatment? Periodontal (gum) treatment? Your bite adjusted? Any teeth removed? Oral surgery? Sore gums? A serious injury to your mouth or head? If yes, please describe the injury:  ARE YOU: A current smoker/vaper? If so when did you quit? A contact sport participant? Pregnant? If yes, how many weeks? Breast Feeding?				
DENTAL HISTORY  What is the purpose of your visit today?  How long since your last last DENTAL VISIT?  Less than 1 year ago Approx. 1 year ago More than 1 year ago More than 2 years  Don't Remember  What is your home oral hygiene routine? (e.g. Electric or manual toothbrush, brush 2 times a day, flossing)  ARE ANY TEETH SENSITIVE TO: Hot or cold? Sweet tastes? Biting or chewing?  HAVE YOU EXPERIENCED: Clicking or popping of the jaw? Ear, face, jaw pain? Difficulty opening or closing your mouth? Loose teeth or a change in your bite? Food trapping between your teeth?  DO YOU:  Grind your teeth? Wear a dental night guard? Have a ching jaws, especially in the mornings? Have a dry mouth? Suffer from occasional bad breath? Have a history of gum disease or tooth loss? Bite your cheeks, lips or tongue often? HAVE YOU EVER HAD: Orthodontic treatment? Periodontal (gum) treatment? Your bite adjusted? Ary teeth removed? Oral surgery? Sore gums? A serious injury to your mouth or head? If yes, please describe the injury:  ACUITED APPRIENCED: If you how many per day? A past smoker/vaper? If yes how many per day? A past smoker/vaper? If yes how many weeks? Breast Feeding?	,	rres strate islander descent.	Reference Number.	
DENTAL HISTORY  What is the purpose of your visit today?  How long since your last Jebnal Visit?  Less than 1 year ago Approx. 1 year ago More than 2 years  What is your home oral hygiene routine? (e.g. Electric or manual toothbrush, brush 2 times a day, flossing)  ARE ANY TEETH SENSITIVE TO: Hot or cold? Sweet tastes? Biting or chewing?  HAVE YOU EXPERIENCED: Clicking or popping of the jaw? Ear, face, jaw pain? Difficulty opening or closing your mouth? Lose teeth or a change in your bite? Food trapping between your teeth?  When a dental night guard? Have a history of gur disease or tooth loss? Bite your cheeks, lips or toongue often? Have a history of gur disease or tooth loss? Bite your cheeks, lips or toongue often? Have a history of gur disease or tooth loss? Bite your cheeks, lips or toongue often? Have a history of gur disease or tooth loss? Bite your cheeks, lips or toongue often? Have a history of gur disease or tooth				
What is the purpose of your visit today?  What is the purpose of your visit today?  When were your last DENTAL VISIT?  Less than 1 year ago Approx. 1 year ago More than 2 years  More than 2 years  What is your home oral hygiene routine? (eg. Electric or manual toothbrush, brush 2 times a day, flossing)  ARE ANY TEETH SENSITIVE TO: Hot or cold? Sweet tastes? Biting or chewing?  HAVE YOU EXPERIENCED: Clicking or popping of the jaw? Ear, face, jaw pain? Difficulty opening or closing your mouth? Loose teeth or a change in your bite? Food trapping between your teeth?  What is the purpose of your visit today? Wear a dental night guard? Have a ching jaws, especially in the mornings? Have a dry mouth? Wear a dental night guard? Have a dental night guard? Have a ding jaws, especially in the mornings? Have a dry mouth?  Suffer from occasional bad breath? Have a history of gum disease or tooth loss? Bite your cheeks, lips or tongue often? HAVE YOU EVER HAD: Orthodontic treatment? Periodontal (gum) treatment? Your bite adjusted? Ary teeth removed? Oral surgery? Sore gums? A serious injury to your mouth or head? If yes, please describe the injury:  ARE YOU:  Acurrent smoker/vaper? If yes how many per day? A past smoker/vaper? If so when did you quit? A contact sport participant? Pregnant? If yes, how many weeks? Breast Feeding?	Do you require an interpre	ter? YES / NO		
What is the purpose of your visit today?  What is the purpose of your visit today?  When were your last DENTAL VISIT?  Less than 1 year ago Approx. 1 year ago More than 2 years  More than 2 years  What is your home oral hygiene routine? (eg. Electric or manual toothbrush, brush 2 times a day, flossing)  ARE ANY TEETH SENSITIVE TO: Hot or cold? Sweet tastes? Biting or chewing?  HAVE YOU EXPERIENCED: Clicking or popping of the jaw? Ear, face, jaw pain? Difficulty opening or closing your mouth? Loose teeth or a change in your bite? Food trapping between your teeth?  What is the purpose of your visit today? Wear a dental night guard? Have a ching jaws, especially in the mornings? Have a dry mouth? Wear a dental night guard? Have a dental night guard? Have a ding jaws, especially in the mornings? Have a dry mouth?  Suffer from occasional bad breath? Have a history of gum disease or tooth loss? Bite your cheeks, lips or tongue often? HAVE YOU EVER HAD: Orthodontic treatment? Periodontal (gum) treatment? Your bite adjusted? Ary teeth removed? Oral surgery? Sore gums? A serious injury to your mouth or head? If yes, please describe the injury:  ARE YOU:  Acurrent smoker/vaper? If yes how many per day? A past smoker/vaper? If so when did you quit? A contact sport participant? Pregnant? If yes, how many weeks? Breast Feeding?				
What is the purpose of your visit today?  How long since your last DENTAL VISIT?  Less than 1 year ago   Approx. 1 year ago   More than 1 year ago   Don't Remember    What is your home oral hygiene routine? (e.g. Electric or manual toothbrush, brush 2 times a day, flossing)  ARE ANY TEETH SENSITIVE TO: Hot or cold? Sweet tastes? Biting or chewing?  HAVE YOU EXPERIENCED: Clicking or popping of the jaw? Ear, face, jaw pain? Difficulty opening or closing your mouth? Difficulty opening or closing your mouth? Loose teeth or a change in your bite? Food trapping between your teeth?  When were your last Have a ching jaws, especially in the mornings? Have a dhry mouth?  Suffer from occasional bad breath? Have a history of gum disease or tooth loss? Bite your cheeks, lips or tongue often? HAVE YOU EVER HAD: Orthodontic treatment? Periodontal (gum) treatment? Your bite adjusted? Any teeth removed? Oral surgery? Sore gums? A serious injury to your mouth or head? If yes, please describe the injury:  ARE YOU:  A current smoker/vaper? If so when did you quit? A contact sport participant? Pregnant? If yes, how many weeks? Breast Feeding?	<b>DENTAL HISTOF</b>	RY		
How long since your last DENTAL VISIT?  Less than 1 year ago   Approx. 1 year ago   More than 2 years   Don't Remember    What is your home oral hygiene routine? (e.g. Electric or manual toothbrush, brush 2 times a day, flossing)  ARE ANY TEETH SENSITIVE TO: Hot or cold? Sweet tastes? Biting or chewing?  HAVE YOU EXPERIENCED: Clicking or popping of the jaw? Ear, face, jaw pain? Difficulty opening or closing your mouth? Loose teeth or a change in your bite? Food trapping between your teeth?  When a ching jaw, especially in the mornings? Have a dry mouth? Suffer from occasional bad breath? Have a history of gum disease or tooth loss? Bite your cheeks, lips or tongue often? Have YOU EVER HAD: Orthodontic treatment? Periodontal (gum) treatment? Your bite adjusted? Any teeth removed? Oral surgery? Sore gums? A serious injury to your mouth or head? If yes, please describe the injury:  ARE YOU:  A current smoker/vaper? If so when did you quit? A contact sport participant? Pregnant? If yes, how many weeks? Breast Feeding?	What is the purpose of you	r visit today?		
Have a dry mouth?  Suffer from occasional bad breath?  Less than 1 year ago Approx. 1 year ago More than 2 years  More than 2 years  Don't Remember  What is your home oral hygiene routine? (eg. Electric or manual toothbrush, brush 2 times a day, flossing)  ARE ANY TEETH SENSITIVE TO:  Hot or cold? Sweet tastes? Biting or chewing?  HAVE YOU EXPERIENCED:  Clicking or popping of the jaw? Ear, face, jaw pain? Difficulty opening or closing your mouth? Difficulty chewing?  Cold sores or blisters around your mouth? Loose teeth or a change in your bite? Food trapping between your teeth?  When were your last DENTAL X-RAYS taken? Less than 1 year ago More than 2 years Bite your cheeks, lips or tongue often?  HAVE YOU EVER HAD: Orthodontic treatment?  Your bite adjusted? Any teeth removed? Oral surgery? Sore gums? A serious injury to your mouth or head? If yes, please describe the injury:  A current smoker/vaper? If yes how many per day? A past smoker/vaper? If so when did you quit? A contact sport participant? Pregnant? If yes, how many weeks? Breast Feeding?		<b>,</b> -		
How long since your last DENTAL VISIT?  Less than 1 year ago Approx. 1 year ago More than 2 years More than 2 years What is your home oral hygiene routine? (e.g. Electric or manual toothbrush, brush 2 times a day, flossing)  ARE ANY TEETH SENSITIVE TO: Hot or cold? Sweet tastes? Biting or chewing?  HAVE YOU EXPERIENCED:  Clicking or popping of the jaw? Ear, face, jaw pain? Difficulty opening or closing your mouth? Difficulty chewing?  Cold sores or blisters around your mouth? Loose teeth or a change in your bite and so the safe ago More than 1 year ago More than 2 years  Bite your cheeks, lips or tongue often?  HAVE YOU EVER HAD: Orthodontic treatment?  Periodontal (gum) treatment?  Your bite adjusted? Any teeth removed? Oral surgery? Sore gums? A serious injury to your mouth or head?  If yes, please describe the injury:  A current smoker/vaper?  If yes how many per day? A past smoker/vaper?  If so when did you quit? A contact sport participant?  Pregnant?  If yes, how many weeks? Breast Feeding?				
last DENTAL VISIT? Less than 1 year ago Approx. 1 year ago More than 2 years  What is your home oral hygiene routine? (e.g. Electric or manual toothbrush, brush 2 times a day, flossing)  ARE ANY TEETH SENSITIVE TO: Hot or cold? Sweet tastes? Biting or chewing?  HAVE YOU EXPERIENCED: Clicking or popping of the jaw? Ear, face, jaw pain? Difficulty opening or closing your mouth? Difficulty chewing? Cold sores or blisters around your mouth? Loose teeth or a change in your bite?  Dental X-RAYS taken? Less than 1 year ago More than 1 year ago Don't Remember  Orthodontic treatment? Periodontal (gum) treatment?  Your bite adjusted? Any teeth removed? Oral surgery? Sore gums? A serious injury to your mouth or head?  If yes, please describe the injury:  ARE YOU:  A current smoker/vaper?  If yes how many per day? A past smoker/vaper?  If so when did you quit? A contact sport participant?  Pregnant?  If yes, how many weeks? Breast Feeding?	How long since your	When were your last		
Less than 1 year ago Approx. 1 year ago More than 2 years  What is your home oral hygiene routine? (e.g. Electric or manual toothbrush, brush 2 times a day, flossing)  ARE ANY TEETH SENSITIVE TO:  Hot or cold? Sweet tastes? Biting or chewing?  HAVE YOU EXPERIENCED:  Clicking or popping of the jaw? Ear, face, jaw pain? Difficulty opening or closing your mouth? Difficulty chewing? Cold sores or blisters around your mouth? Loose teeth or a change in your bite? Food trapping between your teeth?  More than 1 year ago Bite your cheeks, lips or tongue often?  HAVE YOU EVER HAD: Orthodontic treatment? Periodontal (gum) treatment?  Your bite adjusted? Any teeth removed? Oral surgery? Sore gums? A serious injury to your mouth or head?  If yes, please describe the injury:  A current smoker/vaper? If yes how many per day? A past smoker/vaper? If so when did you quit? A contact sport participant? Pregnant? If yes, how many weeks? Breast Feeding?	last <b>DENTAL VISIT</b> ?			
Approx. 1 year ago More than 1 year ago Don't Remember  What is your home oral hygiene routine? (e.g. Electric or manual toothbrush, brush 2 times a day, flossing)  ARE ANY TEETH SENSITIVE TO: Hot or cold? Sweet tastes? Biting or chewing?  HAVE YOU EXPERIENCED:  Clicking or popping of the jaw? Ear, face, jaw pain? Difficulty opening or closing your mouth? Difficulty chewing? Cold sores or blisters around your mouth? Loose teeth or a change in your bite? Food trapping between your teeth?  More than 1 year ago Don't Remember  Orthodontic treatment? Periodontal (gum) treatment?  Your bite adjusted? Any teeth removed? Oral surgery? Sore gums? A serious injury to your mouth or head?  If yes, please describe the injury:  ARE YOU:  A current smoker/vaper? If yes how many per day? A past smoker/vaper? If so when did you quit? A contact sport participant? Pregnant? If yes, how many weeks? Breast Feeding?	Less than 1 year ago	Less than 1 year ago		
More than 2 years  Don't Remember  What is your home oral hygiene routine? (e.g. Electric or manual toothbrush, brush 2 times a day, flossing)  ARE ANY TEETH SENSITIVE TO: Hot or cold? Sweet tastes? Biting or chewing?  HAVE YOU EXPERIENCED: Clicking or popping of the jaw? Ear, face, jaw pain? Difficulty opening or closing your mouth? Difficulty chewing? Cold sores or blisters around your mouth? Loose teeth or a change in your bite? Food trapping between your teeth?  Orthodontic treatment? Periodontal (gum) treatment? Pour bite adjusted? Any teeth removed? Oral surgery? Sore gums? A serious injury to your mouth or head? If yes, please describe the injury:  A current smoker/vaper? If yes how many per day? A past smoker/vaper? If so when did you quit? A contact sport participant? Pregnant? If yes, how many weeks? Breast Feeding?	Approx. 1 year ago	More than 1 year ago		
What is your home oral hygiene routine? (e.g. Electric or manual toothbrush, brush 2 times a day, flossing)  ARE ANY TEETH SENSITIVE TO: Hot or cold? Sweet tastes? Biting or chewing?  HAVE YOU EXPERIENCED: Clicking or popping of the jaw? Ear, face, jaw pain? Difficulty opening or closing your mouth? Difficulty chewing? Cold sores or blisters around your mouth? Loose teeth or a change in your bite? Food trapping between your teeth?  Periodontal (gum) treatment? Your bite adjusted? Any teeth removed? Oral surgery? Sore gums? A serious injury to your mouth or head? If yes, please describe the injury:  A current smoker/vaper? If yes how many per day? A past smoker/vaper? If so when did you quit? A contact sport participant? Pregnant? If yes, how many weeks? Breast Feeding?	More than 2 years	Don't Remember		
Your bite adjusted? Any teeth removed? Oral surgery? Sore gums? A serious injury to your mouth or head? If yes, please describe the injury:  ARE YOU:  HAVE YOU EXPERIENCED: Clicking or popping of the jaw? Ear, face, jaw pain? Difficulty opening or closing your mouth? Difficulty chewing? Cold sores or blisters around your mouth? Loose teeth or a change in your bite? Food trapping between your teeth?  Your bite adjusted? Any teeth removed? Oral surgery? Sore gums? A serious injury to your mouth or head? If yes, please describe the injury:  A current smoker/vaper? If yes how many per day? A past smoker/vaper? If so when did you quit? A contact sport participant? Pregnant? If yes, how many weeks? Breast Feeding?				
ARE ANY TEETH SENSITIVE TO:  Hot or cold? Sweet tastes? Biting or chewing?  Clicking or popping of the jaw? Ear, face, jaw pain? Difficulty opening or closing your mouth? Difficulty chewing?  Cold sores or blisters around your mouth? Loose teeth or a change in your bite? Food trapping between your teeth?  Are the removed?  Oral surgery? Sore gums?  A serious injury to your mouth or head?  If yes, please describe the injury:  ARE YOU:  A current smoker/vaper?  If yes how many per day?  A past smoker/vaper?  If so when did you quit?  A contact sport participant?  Pregnant?  If yes, how many weeks?  Breast Feeding?				
ARE ANY TEETH SENSITIVE TO:  Hot or cold?  Sweet tastes?  Biting or chewing?  Clicking or popping of the jaw? Ear, face, jaw pain? Difficulty opening or closing your mouth? Difficulty chewing?  Cold sores or blisters around your mouth? Loose teeth or a change in your beth?  Aserious injury to your mouth or head?  If yes, please describe the injury:  ARE YOU:  A current smoker/vaper?  If yes how many per day?  A past smoker/vaper?  If so when did you quit?  A contact sport participant?  Pregnant?  If yes, how many weeks?  Breast Feeding?	. 0	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
ARE ANY TEETH SENSITIVE TO:  Hot or cold?  Sweet tastes?  Biting or chewing?  HAVE YOU EXPERIENCED:  Clicking or popping of the jaw?  Ear, face, jaw pain?  Difficulty opening or closing your mouth?  Difficulty chewing?  Cold sores or blisters around your mouth?  Loose teeth or a change in your bite?  Food trapping between your teeth?  A serious injury to your mouth or head?  If yes, please describe the injury:  A current smoker/vaper?  If yes how many per day?  A past smoker/vaper?  If so when did you quit?  A contact sport participant?  Pregnant?  If yes, how many weeks?  Breast Feeding?				
ARE ANY TEETH SENSITIVE TO:  Hot or cold?  Sweet tastes?  Biting or chewing?  HAVE YOU EXPERIENCED:  Clicking or popping of the jaw?  Ear, face, jaw pain?  Difficulty opening or closing your mouth?  Difficulty chewing?  Cold sores or blisters around your mouth?  Loose teeth or a change in your bite?  Food trapping between your teeth?  A serious injury to your mouth or head?  If yes, please describe the injury:  A current smoker/vaper?  If yes how many per day?  A past smoker/vaper?  If so when did you quit?  A contact sport participant?  Pregnant?  If yes, how many weeks?  Breast Feeding?				
Hot or cold?  Sweet tastes?  Biting or chewing?  HAVE YOU EXPERIENCED:  Clicking or popping of the jaw?  Ear, face, jaw pain?  Difficulty opening or closing your mouth?  Difficulty chewing?  Cold sores or blisters around your mouth?  Loose teeth or a change in your bite?  Food trapping between your teeth?  If yes, please describe the injury:  ARE YOU:  A current smoker/vaper?  If yes how many per day?  A past smoker/vaper?  If so when did you quit?  A contact sport participant?  Pregnant?  If yes, how many weeks?  Breast Feeding?	ADE ANN TESTIL CONCINIC TO			
Sweet tastes?  Biting or chewing?  ARE YOU:  ARE YOU:  A current smoker/vaper?  If yes how many per day?  A past smoker/vaper?  Difficulty opening or closing your mouth?  Difficulty chewing?  Cold sores or blisters around your mouth?  Loose teeth or a change in your bite?  Food trapping between your teeth?  A current smoker/vaper?  If yes how many per day?  A past smoker/vaper?  If so when did you quit?  A contact sport participant?  Pregnant?  If yes, how many weeks?  Breast Feeding?		IVE 10.		
Biting or chewing?  HAVE YOU EXPERIENCED:  Clicking or popping of the jaw?  Ear, face, jaw pain?  Difficulty opening or closing your mouth?  Difficulty chewing?  Cold sores or blisters around your mouth?  Loose teeth or a change in your bite?  Food trapping between your teeth?  A current smoker/vaper?  If yes how many per day?  A past smoker/vaper?  If so when did you quit?  A contact sport participant?  Pregnant?  If yes, how many weeks?  Breast Feeding?			If yes, please describe the injury:	
ARE YOU:  HAVE YOU EXPERIENCED:  Clicking or popping of the jaw?  Ear, face, jaw pain?  Difficulty opening or closing your mouth?  Difficulty chewing?  Cold sores or blisters around your mouth?  Loose teeth or a change in your bite?  Food trapping between your teeth?  A current smoker/vaper?  If yes how many per day?  A past smoker/vaper?  If so when did you quit?  A contact sport participant?  Pregnant?  If yes, how many weeks?  Breast Feeding?				
Clicking or popping of the jaw?  Ear, face, jaw pain?  Difficulty opening or closing your mouth?  Difficulty chewing?  Cold sores or blisters around your mouth?  Loose teeth or a change in your bite?  Food trapping between your teeth?  If yes how many per day?  A past smoker/vaper?  If so when did you quit?  A contact sport participant?  Pregnant?  If yes, how many weeks?  Breast Feeding?	biting of chewing?		ARE YOU:	
Ear, face, jaw pain?  Difficulty opening or closing your mouth?  Difficulty chewing?  Cold sores or blisters around your mouth?  Loose teeth or a change in your bite?  Food trapping between your teeth?  A past smoker/vaper?  If so when did you quit?  A contact sport participant?  Pregnant?  If yes, how many weeks?  Breast Feeding?	HAVE YOU EXPERIENCE	D:	A current smoker/vaper?	
Difficulty opening or closing your mouth?  Difficulty chewing?  Cold sores or blisters around your mouth?  Loose teeth or a change in your bite?  Food trapping between your teeth?  If so when did you quit?  A contact sport participant?  Pregnant?  If yes, how many weeks?  Breast Feeding?	Clicking or popping of the jaw?		If yes how many per day?	
Difficulty chewing?  Cold sores or blisters around your mouth?  Loose teeth or a change in your bite?  Food trapping between your teeth?  A contact sport participant?  Pregnant?  If yes, how many weeks?  Breast Feeding?	Ear, face, jaw pain?		A past smoker/vaper?	
Cold sores or blisters around your mouth?  Loose teeth or a change in your bite?  Food trapping between your teeth?  Pregnant?  If yes, how many weeks?  Breast Feeding?	Difficulty opening or closing your mouth?		If so when did you quit?	
Loose teeth or a change in your bite?  Food trapping between your teeth?  If yes, how many weeks?  Breast Feeding?	Difficulty chewing?		A contact sport participant?	
Loose teeth or a change in your bite?  Food trapping between your teeth?  If yes, how many weeks?  Breast Feeding?	Cold sores or blisters around your mouth?			
Food trapping between your teeth?  Breast Feeding?				

## **NEW PATIENT HISTORY FORM**



## **MEDICAL HISTORY**

It is important to know details about your medical history as these could affect the success of your dental treatment and how your treating dental practitioner can provide this treatment safely for you. The information you provide is confidential and will be handled in accordance with our privacy policy.

Are you receiving any medical treatment at present?	Are you taking any medication or supplements? (These can
YES / NO	include herbal preparations, vitamins, supplements, cold/flu treatments, sleeping pills, pain relievers, injections, implants,
If yes, please provide details:	etc.) We ask this so that your treating dental practitioner can take precautions to minimise risks and known negative interactions.
Name of your medical practitioner/specialist:	YES / NO
	If yes please list:
Surgery contact number:	
Have you been hospitalised in the last 12 months?	
YES / NO	
If yes, please list why:	

### PLEASE INDICATE IF YOU HAVE HAD OR ARE BEING TREATED FOR ANY OF THE FOLLOWING:

Heart Condition / Heart Surgery Mitral Valve Prolapse Heart Valve / Pacemaker Stroke Rheumatic Fever Polymyalgia Lupus (SLE) Diet (special/restricted) Digestive Problems Gastroesophageal Reflux Gastric Ulcers Circulatory Problems Blood Pressure (high/low) Kidney / Renal Disease Liver Problems / Jaundice Diabetes Thyroid Disease Emphysema Chronic Cough Tuberculosis Lung Condition Bronchitis	
Heart Valve / Pacemaker  Stroke  Rheumatic Fever  Polymyalgia  Lupus (SLE)  Diet (special/restricted)  Digestive Problems  Gastroesophageal Reflux  Gastric Ulcers  Circulatory Problems  Blood Pressure (high/low)  Kidney / Renal Disease  Liver Problems / Jaundice  Diabetes  Thyroid Disease  Emphysema  Chronic Cough  Tuberculosis  Lung Condition	Heart Condition / Heart Surgery
Stroke Rheumatic Fever Polymyalgia Lupus (SLE) Diet (special/restricted) Digestive Problems Gastroesophageal Reflux Gastric Ulcers Circulatory Problems Blood Pressure (high/low) Kidney / Renal Disease Liver Problems / Jaundice Diabetes Thyroid Disease Emphysema Chronic Cough Tuberculosis Lung Condition	Mitral Valve Prolapse
Rheumatic Fever Polymyalgia Lupus (SLE) Diet (special/restricted) Digestive Problems Gastroesophageal Reflux Gastric Ulcers Circulatory Problems Blood Pressure (high/low) Kidney / Renal Disease Liver Problems / Jaundice Diabetes Thyroid Disease Emphysema Chronic Cough Tuberculosis Lung Condition	Heart Valve / Pacemaker
Polymyalgia Lupus (SLE) Diet (special/restricted) Digestive Problems Gastroesophageal Reflux Gastric Ulcers Circulatory Problems Blood Pressure (high/low) Kidney / Renal Disease Liver Problems / Jaundice Diabetes Thyroid Disease Emphysema Chronic Cough Tuberculosis Lung Condition	Stroke
Lupus (SLE)  Diet (special/restricted)  Digestive Problems  Gastroesophageal Reflux  Gastric Ulcers  Circulatory Problems  Blood Pressure (high/low)  Kidney / Renal Disease  Liver Problems / Jaundice  Diabetes  Thyroid Disease  Emphysema  Chronic Cough  Tuberculosis  Lung Condition	Rheumatic Fever
Diet (special/restricted)  Digestive Problems  Gastroesophageal Reflux  Gastric Ulcers  Circulatory Problems  Blood Pressure (high/low)  Kidney / Renal Disease  Liver Problems / Jaundice  Diabetes  Thyroid Disease  Emphysema  Chronic Cough  Tuberculosis  Lung Condition	Polymyalgia
Digestive Problems Gastroesophageal Reflux Gastric Ulcers Circulatory Problems Blood Pressure (high/low) Kidney / Renal Disease Liver Problems / Jaundice Diabetes Thyroid Disease Emphysema Chronic Cough Tuberculosis Lung Condition	Lupus (SLE)
Gastroesophageal Reflux Gastric Ulcers Circulatory Problems Blood Pressure (high/low) Kidney / Renal Disease Liver Problems / Jaundice Diabetes Thyroid Disease Emphysema Chronic Cough Tuberculosis Lung Condition	Diet (special/restricted)
Gastric Ulcers Circulatory Problems Blood Pressure (high/low) Kidney / Renal Disease Liver Problems / Jaundice Diabetes Thyroid Disease Emphysema Chronic Cough Tuberculosis Lung Condition	Digestive Problems
Circulatory Problems Blood Pressure (high/low) Kidney / Renal Disease Liver Problems / Jaundice Diabetes Thyroid Disease Emphysema Chronic Cough Tuberculosis Lung Condition	Gastroesophageal Reflux
Blood Pressure (high/low) Kidney / Renal Disease Liver Problems / Jaundice Diabetes Thyroid Disease Emphysema Chronic Cough Tuberculosis Lung Condition	Gastric Ulcers
Kidney / Renal Disease Liver Problems / Jaundice Diabetes Thyroid Disease Emphysema Chronic Cough Tuberculosis Lung Condition	Circulatory Problems
Liver Problems / Jaundice  Diabetes  Thyroid Disease  Emphysema  Chronic Cough  Tuberculosis  Lung Condition	Blood Pressure (high/low)
Diabetes Thyroid Disease Emphysema Chronic Cough Tuberculosis Lung Condition	Kidney / Renal Disease
Thyroid Disease  Emphysema Chronic Cough Tuberculosis Lung Condition	Liver Problems / Jaundice
Emphysema Chronic Cough Tuberculosis Lung Condition	Diabetes
Chronic Cough Tuberculosis Lung Condition	Thyroid Disease
Tuberculosis Lung Condition	Emphysema
Lung Condition	Chronic Cough
	Tuberculosis
Bronchitis	Lung Condition
Di Oricina)	Bronchitis

Asthma	
Hay fever	
Sinus Trouble	
Allergies (medicine, antibiotics, pain relievers, anaesthetic, antibiotics, contact allergies)	
Latex sensitivity	
Snoring / Sleep Apnoea	
Hepatitis	
Blood Borne Virus (AIDS/HIV, Hep B/C)	
Blood Transfusion	
Blood or Bleeding Disorder	
Anaemia	
Bruise or Bleed Easily	
Leukaemia	
Cancer	
Tumour History	
Radiation / Chemotherapy	
Neurological Disorder	
Epilepsy or Seizures	
Fainting or Dizzy Spells	
Anxiety	
Depression	
Psychiatric Condition	

Osteoporosis	
Arthritis / Rheumatism	
Bone Disorder or Disease	
Knee Reconstruction	
Prosthetic Implant	
Artificial Joints (hip, knee)	
Jaw / Neck Injury or Pain	
Steroid Therapy	
Transplant (organ, marrow)	
Infectious Disease (any)	
Other	
If you have answered yes or other please provide details:	,
Any other relevant information:	

## **NEW PATIENT HISTORY FORM**



## HOW DID YOU HEAR ABOUT THE CLINIC?

Signage / Walk by	
Doctor / Dentist Referral	
Internet / Google Search	
Business Directory	

Health Fund	
Flyer / Leaflet	
School / Club/Sponsor	
Magazine or Print Media	

Radio Advertising	
Social Media	
Word of Mouth / Referral	
Other	

## YOUR TREATMENT

Maven Dental Group Pty Ltd manages dental centres in Australia and provides dental practitioners with the administrative and non-dental services that those dental practitioners need to provide you with dental services. Normally, those dental practitioners are not our employees and, in providing dental services and doing other things, are operating their own independent businesses. Your treating dental practitioner is ultimately responsible for your care and you should address any queries or concerns that you have regarding your treatment to them.

### **CONSENT FOR TREATMENT**

- 1. I have answered all questions to the best of my knowledge. Should further information be required, you have my permission to contact my medical practitioner, who may release such information to you.
- 2. I consent to a dental practitioner or designated team member to take x-rays, study models, photographs and other diagnostic aides as deemed appropriate by a dental practitioner to make a thorough dental diagnosis.
- 3. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. I also understand that if for any reason recovery of funds is required, and costs involved will be at my expense. I understand that if I cancel an appointment within 24 hours of my appointment, I may be liable for payment of a cancellation fee.

Patient Name:	Date:
Patient Signature:	Parent/Guardian:

## WE RESPECT YOUR PRIVACY

Please read this Privacy Collection Statement to see how we use your personal information.

Maven Dental Group Pty Ltd collects your personal information for purposes related to (or in the case of sensitive information, directly related to) our functions or activities including facilitating the delivery of dental services to you by independent dental practitioners, informing you of services which may be relevant to you and to communicate with you. We may not be able to facilitate the delivery of health services to you if you do not provide this information. Your personal information may be disclosed to our related bodies corporate, dental practitioners and third-party services providers, which may include those located overseas.

\*Please refer to our Privacy Policy which is available at reception and at mavendental.com.au/policy/privacy-policy/ for full details of how we handle your personal information.

### If you would like to:

- Inform us that you do not wish to receive promotional material,
- Request access to or the correction of information we hold about you,
- Make a complaint about our treatment of your privacy,

#### You can contact us on:

privacy@mavendental.com.au OR mail to: The Privacy Officer, Maven Dental Group Pty Ltd, PO Box 5454, West End QLD 4101.

I acknowledge that I have read, understand and agree to my personal and sensitive information being handled in accordance with, Maven Dental Group's Privacy Collection Statement and Privacy Policy\*.

Name:	Signature:	Date:
	0.0000000000000000000000000000000000000	