

# Your Health History

So we can ensure we are looking after your needs, please review and complete the following:

Surname:.....Mr/Mrs/Ms/Miss/Master/Dr

First Name:..... Date Of Birth: ...../...../.....

Address:..... Postcode:.....

Private Phone:..... Mobile:..... Business Phone:.....

Email:..... Occupation:.....

Recommended By: ..... Purpose Of Visit:.....

Have you had any of the following? Please tick  if yes. Leave blank if no.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Any Heart Problems                                    | <input type="checkbox"/> Sinus Trouble                          | <input type="checkbox"/> Allergies to Latex               |
| <input type="checkbox"/> High or Low Blood Pressure                            | <input type="checkbox"/> Tumour History                         | <input type="checkbox"/> Anaemia or other Blood Disorders |
| <input type="checkbox"/> Artificial Joints                                     | <input type="checkbox"/> Allergies to Penicillin                | <input type="checkbox"/> Excessive Bruising               |
| <input type="checkbox"/> Rheumatic Fever                                       | <input type="checkbox"/> Allergies to Anaesthetics              | <input type="checkbox"/> Diabetes                         |
| <input type="checkbox"/> Excessive Bleeding                                    | <input type="checkbox"/> Allergies to Medications (please list) | <input type="checkbox"/> Asthma                           |
| <input type="checkbox"/> Stomach Ulcers  | .....   | <input type="checkbox"/> Liver or Kidney Problems         |
| <input type="checkbox"/> Are you pregnant? If yes, due date: ...../...../..... |   | <input type="checkbox"/> Hepatitis: A B C D E             |

Any other health problems you would like us to know?.....

Are you currently taking any medications? Please list:.....

# Dental History

Yes No

- Does your jaw click or hurt? .....
- Do you feel you grind your teeth? .....
- Have you ever had orthodontic treatment (Braces)? .....
- Do you wear a dental night guard? .....
- Have you ever had your bite adjusted? .....
- Do you bite your lips or cheeks often? .....
- Do you smoke? .....
- Do you think you have occasional bad breath? .....
- Do you experience sensitivity with hot or cold? .....
- Do your teeth hurt when you bite hard? .....
- Does floss ever tear between your teeth? .....
- Does food get trapped between your teeth? .....
- How often do you brush? .....
- How often do you floss? .....
- Is there anything else you would like us to know?.....

How long since your last dental appointment?..... How often do you go to the dentist? .....

The name of your Medical Doctor:.....

Address:..... Postcode:.....

## Consent for Treatment

1. I hereby authorise the dentist or diagnosed staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.
2. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistant as required to provide proper care.
3. I agree to the use of anaesthetics as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand that payment is due at the time of service unless other arrangements have been made.

Patients Signature:..... Date: ...../...../.....

Parent/Responsible Party's Signature:..... Relationship to Patient:.....