Medical / Dental History Form

MaxicareDental

Title: Dr / Mr / Mrs / Miss / Ms   Name:____

Surname   First Name

Date of Birth: ____ /____/_____   Your Occupation: ______________________________

Home Address: ____

Suburb:_____________________   State: ___________   Postcode: _________

Home Phone:_________________Mobile Phone:______________Work Phone: ______________

E-mail address:_____________________________@_____________________________

Emergency Contact Name:___________________________Phone: ______________________

Medical Doctors Name_____________________________Phone: _______________________

Health Fund Provider:___________________________Membership Number: ______________

DVA Number (if applicable): _________________________

How did you hear about us? ____

PLEASE CIRCLE AND PROVIDE DETAILS:

1. Are you receiving any medical treatment at present? YES / NO

   Details: ____

2. Have you been in hospital during the past two years? YES / NO

   Details: ____

3. Are you currently taking any prescribed or over the counter medication? YES / NO

   Details: ____

4. Are you allergic to any medication, tablets or antibiotics? YES / NO

   Details: ____

5. Have you had any prosthetic surgery? (e.g. heart valve, stents, knee or hip replacements) YES / NO

   Details: ____

6. Are you currently pregnant or breastfeeding? (Females Only) YES / NO

7. Do you smoke? YES / NO   How many per day? _________

8. Do you drink alcohol? YES / NO   Amount per day or week ____________________________

9. Have you ever had or are receiving treatment for cancer? YES / NO

   Details: ____

DO YOU HAVE OR EVER HAD, ANY OF THE FOLLOWING CONDITIONS?

Please circle YES or NO to each condition.

Heart condition	YES / NO	High blood pressure	YES / NO	Low blood pressure	YES / NO
Steroid therapy	YES / NO	Kidney disease	YES / NO	Prosthetic implant	YES / NO
Rheumatic fever	YES / NO	Excessive bleeding	YES / NO	Cardiac pacemaker	YES / NO
Epilepsy	YES / NO	Stroke	YES / NO	Digestive condition	YES / NO
Asthma	YES / NO	Cancer	YES / NO	Liver Conditions	YES / NO
Diabetes	YES / NO	Tuberculosis	YES / NO	Blood borne virus	YES / NO
Thyroid disease	YES / NO	Lung condition	YES / NO	Bone disease	YES / NO
Depression	YES / NO	Blood disease	YES / NO	Radiation therapy	YES / NO
Sinus trouble	YES / NO	Bisphosphonate meds	YES / NO	Arthritis	YES / NO

Please list any allergies you have (e.g latex, gluten etc): ______________________________

Please detail any condition not listed here: ______________________________

Dental History

1. When was your last dental examination carried out?______________________________

2. Have you ever been diagnosed with or been treated for gum disease? YES / NO

3. Are you currently experiencing pain or have a dental problem? YES / NO

   Details: ______________________________

4. Are you nervous, anxious or ever had a bad experience at a dental visit? YES / NO

   Details: ______________________________

5. Are you happy with the appearance of your teeth? YES / NO

   Details: ______________________________

6. Do you want to discuss or find out more about any of the following:

Please CIRCLE:

Replacement of Missing Teeth   Cosmetic Appearance   Removal of Wisdom Teeth

Tooth Whitening   Bad Breath   Bleeding Gums   Tooth Grinding/Clenching

Replacement of silver (mercury) fillings   Dentures   Implants

All information we hold about you is strictly confidential and never shared with third parties without your explicit consent.

Patients Signature: ______________________________

If under 18 years old:
Guardian Signature:______________________Print Name: ______________________

Date:________/______/______