Cairns Precision Dental Group

MEDICAL/MEDICATION HEALTH HISTORY FORM

Personal Information

SURNAME: _____ Mr / Mrs / Ms / Mst / Miss / Dr _____

FIRST NAME: _____ DATE OF BIRTH: _____/_____/_____

POSTAL ADDRESS: _____

MOBILE: _____ BUSINESS PHONE: _____ HOME PHONE _____

E-MAIL: _____

OCCUPATION: _____ WHERE: _____

NEXT OF KIN: _____ PHONE:_____RELATIONSHIP: _____

NAME OF PRIVATE HEALTH FUND FOR DENTAL: _____

How would you like to be notified of your next appointment SMS □ E-MAIL □ PHONE □

Where did you hear about us? Website □ Health Engine □ Internet search □ Advertising □ Facebook □ Other □

Who can we thank for referring you to us _____

Please note: We require 2 working days notice when rescheduling or cancelling an appointment

Health History

Are you pregnant? Yes □ No □

Are you a smoker? Yes □ No □ Quit □ (Date quit)

Have you had any serious illnesses or operations? If yes, describe

Are you taking or scheduled to begin taking injections / medications to treat Osteoporosis, Paget's Disease, Hypercalcaemia or Malignancy e.g. **Prolia**, Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa or Bonefos

Check (√) if you have or have had any of the following:

High Blood Pressure	□	Cancer	□	Jaw Pain	□
Heart Problems	□	Chemotherapy	□	Kidney Disease	□
Pacemaker	□	Circulatory Problems	□	Liver Disease	□
Artificial Heart Valves	□	Covid-19	□	Radiation Treatment	□
Rheumatic Fever	□	Diabetes	□	Respiratory Disease	□
Bleeding/Haemophilia	□	Epilepsy	□	Stomach Ulcers	□
Anaemia	□	Emphysema	□	Thyroid Problems	□
Arthritis, Rheumatism	□	Fainting / Dizziness	□		
Artificial Joints	□	Headaches	□	Other Conditions (List below)	□
Asthma	□	Herpes	□		
Back Problems	□	Hepatitis A B C D E			
Blood Disease	□	HIV/AIDS			

Medications	Allergies	
List medications you are currently taking	Aspirin	□
	Barbiturates (sleeping pills)	□
	Codeine	□
	Local Anaesthetic	□
	Penicillin	□
	Latex	□
	Sulphur	□
	Other (list below)	□

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Are you aware of the impact dental health may have on your general health? Yes ☐ No ☐

Additional Information		
	Yes	**No**
Does your jaw "click" or hurt	☐	☐
Do you feel you grind your teeth or wear a nightguard	☐	☐
Have you ever had orthodontic treatment	☐	☐
Have you ever had periodontal (gum) treatment	☐	☐
Do you bite your lips or cheeks often	☐	☐
Do you think you have occasional bad breath	☐	☐
Do your gums ever bleed when you clean your teeth	☐	☐
Do you experience sensitivity with hot/cold	☐	☐
Do your teeth ever hurt when you bite hard	☐	☐
Does floss ever tear between your teeth	☐	☐
Does food get jammed between your teeth	☐	☐
Is there anything else you would like us to know	☐	☐
If so please list		

How long since your last dental appointment		
How often do you have dental examinations		
Previous dental-rays were taken	Less than 1 year ☐	Longer than 1 year ☐

Name of your Doctor	
Address	
Phone Number	

Consent for Treatment

1. **I hereby authorise the dentist or designated staff to take x-rays, study models, photographs and any other diagnostic images.**

2. **Upon such diagnosis, I authorise the dentist to perform all treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.**

3. **I agree to the use of anaesthetics, sedatives and other medication 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 dependents. I understand that payment is due at the time of service unless other arrangements have been made.**

Patient's Signature: _____ **Date** _____

Parent/Responsible Party's Signature _____ **Relationship to Patient** _____

WE ACCEPT BANKCARD, MASTERCARD, VISA, AMEX , PERSONAL CHEQUE, EFTPOS AND CASH
(WE EXPECT AND APPRECIATE PAYMENT AT TIME OF SERVICE)